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NEW JERSEY REGISTER

HEALTH, DEPARTMENT OF
CHIEF: ALTERNATE HEALTH SYSTEM
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THE JOURNAL OF STATE AGENCY RULEMAKING

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(Includes adopted rules filed through August 16, 1993)

MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: JUNE 21, 1993
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INTERESTED PERSONS

Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **October 7, 1993.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

On occasion, a proposing agency may extend the 30-day comment period to accommodate public hearings or to elicit greater public response to a proposed new rule or amendment. An extended comment deadline will be noted in the heading of a proposal or appear in a subsequent notice in the Register.

At the close of the period for comments, the proposing agency may thereafter adopt a proposal, without change, or with changes not in violation of the rulemaking procedures at N.J.A.C. 1:30-4.3. The adoption becomes effective upon publication in the Register of a notice of adoption, unless otherwise indicated in the adoption notice. Promulgation in the New Jersey Register establishes a new or amended rule as an official part of the New Jersey Administrative Code.

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NEW JERSEY REGISTER

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EXECUTIVE ORDERS

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 97(1993)
Regulatory Advisory Panel

Issued: August 2, 1993.
Effective: August 2, 1993.
Expiration: Indefinite.

WHEREAS, one of the most important objectives of government is to promote public confidence in its integrity and effectiveness; and

WHEREAS, to that end, we must examine the regulatory process to ensure that it is efficient, sensible, and open to the greatest possible degree of public participation; and

WHEREAS, when a regulatory system works well, it provides government with an invaluable opportunity to engage in a meaningful and productive dialogue with the people, and should create a partnership between the government and its citizens; and

WHEREAS, we must guarantee the people of this State greater access to, and greater participation in the rulemaking process; and

WHEREAS, we must work harder to create a regulatory system that carries out the mandates of the law more effectively and at the same time reduces delay and minimizes burdens for our citizens; and

WHEREAS, we must be willing to continually improve the regulatory system, to ensure that it promotes economic development in this State; and

WHEREAS, it is always appropriate to consider revisions to the system, in order to guarantee a system that adapts to changing times and modern challenges; and

WHEREAS, improvements to the regulatory system should not be accomplished by adding new layers of bureaucracy or increasing the size of government; and

WHEREAS, in 1978, Governor Brendan Byrne issued Executive Order No. 66, which required all future regulations to expire no later than five years after adoption; and

WHEREAS, although this action has worked well to improve the regulatory environment in New Jersey, we must continue to build upon these improvements and consider new actions to carry out the goals articulated in Executive Order No. 66;

NOW, THEREFORE, I, JAMES J. FLORIO, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. I hereby direct my Chief Counsel to conduct a comprehensive review of the State's regulatory system, and to present me with recommendations for improvement no later than October 1, 1993. He shall be authorized to provide interim reports.

2. In preparing these recommendations, the Chief Counsel shall convene an Advisory Panel, composed of members to be designated by him, but which shall, at a minimum, be composed of representatives of the private sector, members of the Legislature, other Cabinet Members, and the Director of the Office of Administrative Law. In addition, the Chief Counsel shall consult with the Governor's Management Review Commission as he may deem appropriate. The Chief Counsel shall serve as the Chairman of this Advisory Panel, and shall meet with the Panel in a time and manner he deems most appropriate.

3. The Chief Counsel, in consultation with the Advisory Panel, shall prepare a final report setting forth recommendations for improving the State's regulatory system in a manner designed to maximize efficiency, eliminate duplicative and inconsistent regulations, and provide the greatest degree of effective public participation in the rulemaking process. In particular, the Chief Counsel shall consider the following issues, as well as others he deems relevant:

a. The Chief Counsel shall consider appropriate mechanisms for maximizing public access and participation in the rulemaking process, including:

(1) mandating public hearings under certain circumstances;

(2) improving current provisions allowing members of the public to initiate proceedings for the promulgation, repeal or modification of regulations;

(3) providing opportunities prior to formal proposal for members of the public to comment on regulatory issues; and

(4) improving the current notice requirements for proposed rules to ensure that interested members of the public are made aware of rule proposals.

b. The Chief Counsel shall consider the feasibility of instituting a process of ongoing review of all regulations to eliminate outdated, unnecessary, or duplicative regulations.

c. The Chief Counsel shall examine ways to ensure that rulemaking proposals provide full and fair disclosure which can be easily understood by members of the public.

d. The Chief Counsel shall evaluate procedures for expediting the rulemaking process where appropriate.

e. The Chief Counsel shall examine the scope and effectiveness of Executive Order No. 66 (Byrne) to determine if the sunset requirements set forth therein should be revised or expanded.

f. The Chief Counsel shall review the designation and role of Administrative Practice Officers and make recommendations for changes that would enhance the regulatory process.

g. The Chief Counsel shall make recommendations on how the Office of Administrative Law can most efficiently and effectively review regulations submitted to it for publication.

4. In a manner to be determined by the Chief Counsel, every State department, authority, or instrumentality with rulemaking authority shall forthwith commence a review of the regulatory process in its current form within that department, authority, or instrumentality, and shall recommend changes to the regulatory process.

5. Every State department, authority, and instrumentality of the State of New Jersey shall provide the Chief Counsel and the Advisory Panel with all assistance and cooperation in the implementation of this Order.

6. This Order shall take effect immediately.

(b)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 98(1993)
Tribute to Francisco Baez

Issued: August 11, 1993.
Effective: August 11, 1993.
Expiration: Indefinite.

WHEREAS, Francisco Baez, a 29-year-old resident of Landisville, was tragically killed in a traffic accident on August 10, 1993; and

WHEREAS, Mr. Baez has been a dedicated employee of the Department of Transportation since 1984; and

WHEREAS, it is proper and fitting for the State of New Jersey to honor the memory of Mr. Baez, and to convey our deepest condolences to his family on this tragic occasion;

NOW, THEREFORE, I, JIM FLORIO, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes, do hereby ORDER and DIRECT:

1. The flag of the United States of America and the flag of the State of New Jersey shall be flown at half-staff at all State departments, offices, agencies and instrumentalities during appropriate hours beginning on Thursday, August 12, 1993 and through and including Friday, August 13, 1993 in recognition and mourning of the passing of Francisco Baez.

2. This order shall take effect immediately.

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RULE PROPOSALS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW
Special Hearing Rules
Family Development Hearings
Proposed New Rules: N.J.A.C. 1:10-14.2 and 14.3
Proposed Amendments: N.J.A.C. 1:10-1.1, 9.1, 9.2, 14.1 and 18.1

Authorized By: Jaynee LaVecchia, Director, Office of Administrative Law.

Authority: N.J.S.A. 52:14F-5(e), (f) and (g).

Proposal Number: PRN 1993-505.

Submit comments by October 7, 1993 to:
Jeff S. Masin, Deputy Director
Office of Administrative Law
Quakerbridge Plaza, Bldg. 9, CN 049
Quakerbridge Road
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Social Security Act and implementing Federal regulations have been amended to permit states to establish an enhanced Aid to Families with Dependent Children (AFDC) fraud control program imposing disqualification penalties against individuals found to have intentionally committed an AFDC program violation. 45 C.F.R. §235.113. Pursuant to these amendments, the New Jersey Department of Human Services, Division of Family Development (DFD) has proposed amendments to its rules creating an administrative disqualification process for AFDC cases. 25 N.J.R. 3408(a).

These proposed amendments to the Office of Administrative Law (OAL) special rules for cases from the Division of Family Development ensure that OAL's procedures conform with those proposed amendments and with applicable Federal regulations, 45 C.F.R. §235.110. OAL special rules currently specify the process for hearings in food stamp intentional program violation cases. The disqualification process for AFDC intentional program violations follows the procedures applicable in food stamp intentional program violation cases. Therefore, these amendments apply the food stamp intentional program violation rules to AFDC cases and incorporate appropriate citations to Federal rules.

The proposed amendment to N.J.A.C. 1:10-1.1 updates the agency reference from Division of Economic Assistance to Division of Family Development. Also, the proposed special rules are specifically made applicable to AFDC intentional program violation cases.

The proposed amendment to N.J.A.C. 1:10-9.1 clarifies the rule to indicate that adjournments will be granted the applicant/recipient upon timely application in food stamp cases and intentional program violation cases. In all other matters, the rule continues to require a showing of good cause for an adjournment.

Citations to Federal regulations have been added to three sections: N.J.A.C. 1:10-9.1(d) requiring 10 days notice of an adjournment request in AFDC intentional program violation cases; N.J.A.C. 1:10-9.2(b) requiring 30 days notice of hearing in an AFDC intentional program violation case; and proposed N.J.A.C. 1:10-14.1 requiring *ex parte* hearing if the applicant/recipient fails to appear at an AFDC intentional program violation hearing.

Proposed new rule N.J.A.C. 1:10-14.2 specifies the right of the charged applicant/recipient to remain silent and to refuse to answer questions, as required by Federal regulation. This process has been applied in food stamp intentional program violation hearings, but was not clearly delineated in the OAL rules.

Proposed new rule N.J.A.C. 1:10-14.3 tracks the Federal rules; it permits the administrative law judge to order an independent medical assessment or professional evaluation at CWA or MWD expense for good cause.

N.J.A.C. 1:10-18.1 as amended provides for issuance of an initial decision in all intentional program violation hearings within 21 days of hearing. This timeframe is incorporated to ensure compliance with Federally mandated timeframes.

Social Impact

These proposed amendments and new rules set forth the process for conducting intentional program violation hearings in AFDC cases. These rules conform with the Federal regulations. They provide a hearing process for AFDC intentional program violation cases in coordination with the Division of Family Development.

Economic Impact

In FFY 1992, the Division of Family Development dealt with 3,300 cases involving fraudulent receipt of AFDC benefits. Hearings in some of those matters may be waived by the charged applicant/recipient; other hearings can be consolidated with intentional program violation hearings concerning food stamp benefits. However, an increase in the number of hearings conducted by the OAL can be anticipated. This will result in expenses for the Office of Administrative Law, in terms of both judicial and clerical support time. County welfare agencies will also be required to participate in the program resulting in costs to them as well as to the charged applicant/recipient.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments and new rules do not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments and new rules conform OAL's special hearing rules for contested cases from the Division of Family Development to Federal regulations and recent proposed amendments to the Division's rules.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. APPLICABILITY

1:10-1.1 Applicability

The rules in this chapter shall apply to matters transmitted to the Office of Administrative Law by the Division of [Economic Assistance (DEA)] **Family Development (DFD)** wherein an applicant or recipient disputes the proposed action on eligibility or benefits entitlement by a county welfare agency (CWA) or a local decision or inaction by a municipal welfare department (MWD). These rules also apply to food stamp **and aid to families with dependent children (AFDC)** intentional program violations. Any aspect of the hearing not covered by these special hearing rules shall be governed by the Uniform Administrative Procedure Rules (U.A.P.R.) contained in N.J.A.C. 1:1. To the extent that these rules are inconsistent with the U.A.P.R., these rules shall apply.

SUBCHAPTER 9. SCHEDULING; CLERK'S NOTICES; ADJOURNMENTS

1:10-9.1 Adjournments

(a) In cases involving food stamp benefits, **food stamp intentional program violations and AFDC intentional program violations,** upon timely application an applicant/recipient shall receive one adjournment of the scheduled hearing date for a period of no more than 30 days.

(b)-(c) (No change.)

(d) In cases involving an alleged **food stamp or AFDC** intentional program violation, the recipient must request the adjournment at least 10 days before the scheduled hearing date. 7 C.F.R. 273.16(e)(1)(iii); **45 C.F.R. 235.113(b)(3)(ii)(E).**

1:10-9.2 Notice of hearing

(a) (No change.)

(b) In cases involving an alleged intentional program violation, **the county welfare agency shall send** written notice of the scheduled hearing [shall be sent] to the [applicant/]recipient at least 30 days prior to the hearing. 7 C.F.R. 273.16(e)(3); **45 C.F.R. 235.113(b)(3).**

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SUBCHAPTER 14. CONDUCT OF CASES

1:10-14.1 Attendance at hearing

(a)-(c) (No change.)

(d) If neither the applicant/recipient nor a representative appears at a hearing concerning an intentional program violation and a timely adequate notice of the hearing was given to the applicant/recipient, the hearing shall be conducted *ex parte.* 7 C.F.R. 273.16(e); N.J.A.C. 10:87-11.4(l); **45 C.F.R. 235.113(b)(3)(ii)(d).**

1:10-14.2 Intentional program violation hearings

At an intentional program violation hearing, the charged applicant/recipient has a right to remain silent and may refuse to answer questions. 7 C.F.R. 273.16(e)(2)(iii); 45 C.F.R. 235.113(b)(3)(ii)(K).

1:10-14.3 Independent medical assessment

For good cause, the administrative law judge may order an independent medical assessment or professional evaluation when the hearing involves medical issues. Such medical assessment shall be obtained at CWA or MWD expense. 7 C.F.R. 273.15(m)(2)(v); 7 C.F.R. 273.16(e)(2)(ii); 45 C.F.R. 205.10(a)(iii)(10); 45 C.F.R. 235.113(b)(6).

SUBCHAPTER 18. DECISIONS

1:10-18.1 Initial decision (other than emergency hearing matters)

(a)-(b) (No change.)

(c) In cases involving food stamp **or aid to families with dependent children** intentional program violations, an initial decision shall be issued within 21 days from the date of hearing.

(d) (No change.)

AGRICULTURE

(a)

DIVISION OF REGULATORY SERVICES

Commercial Feeding Stuffs

Proposed Readoption with Amendment: N.J.A.C. 2:68

Authorized By: State Board of Agriculture and Arthur R. Brown, Jr., Secretary, Department of Agriculture.

Authority: N.J.S.A. 4:4-20.10.

Proposal Number: PRN 1993-490.

Submit comments by October 7, 1993 to:

Dhun B. Patel, Ph.D., Director
Division of Regulatory Services
N.J. Department of Agriculture
CN 330
Trenton, New Jersey 08625
Telephone: (609) 292-5575

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 2:68, Commercial Feeding Stuffs, expires on November 7, 1993. The Department of Agriculture has reviewed these rules and determined them to be necessary, reasonable, adequate, efficient, understandable and responsive to the purpose for which they were originally developed. N.J.A.C. 2:68 was originally promulgated to (1) protect farmers and consumers by determining the manufacturer's compliance with the guaranteed content of animal feed and (2) reduce the amount of misbranded and deficient products offered for sale, thereby insuring the quality of feeds and protecting animal growth. The Department of Agriculture adopts and incorporates, by reference, the current edition of the Official Publication of the American Feed Control Officials (AAFCO). The Association standards are recognized by the industry as the most comprehensive and current available. They are accepted throughout most of the United States. A discussion of the rules and regulations regarding feeds is found in the Official Publication of the American Feed Control Officers 1993 edition pages 74 to 82.

In addition to the regulations of feed terms previously referenced, the Department of Agriculture adopts the official pet food regulations, the statement of uniform interpretation and policy, and lists of new animal drugs, certifiable antibiotics and warning statements associated therewith, the permitted analytical variations and the pet food protocols and affidavits as contained in the current edition of the official publication of the Association of American Feed Control Official (referred to above).

This discussion will be found on pages 86-102 of the 1993 edition. A copy is on file in the Director's office, Division of Regulatory Services, New Jersey Department of Agriculture, Health and Agriculture Building, John Fitch Plaza, Trenton, New Jersey 08625. Copies may be procured by writing to Charles P. Rank, Georgia Department of Agriculture, Capital Square, Atlanta, Georgia 30334.

The procedures used to sample and analyze feeds and pet foods is conducted in accordance with methods published in the current addition of the official methods of analysis of the Association of Official Analytical Chemists supplemented by other recognized official procedures. A copy is on file in the Director's office, Division of Regulatory Services, New Jersey Department of Agriculture, Health and Agriculture Building, John Fitch Plaza, Trenton, New Jersey 08625. Copies may also be obtained by writing to AOAC, Fulfillment Coordinator, 2200 Wilson Boulevard, Arlington, Virginia 22201-3301.

The manner by which an interested individual could review or obtain copies of the above referenced documents has been spelled out in footnotes to the rules. The Department is now proposing a separate section, N.J.A.C. 2:68-1.8, to house this information and make it more clearly accessible. The footnotes will be deleted from the chapter once this new section is adopted.

Social Impact

Readoption of N.J.A.C. 2:68 will continue to provide a basis for fair competition in the feed and pet food industries as well as to protect farmers and consumers who purchase commodities covered in this chapter.

Both consumers and manufacturers are affected by the testing of commercial foods. The purpose is to assure adequate and accurate labeling information. The labeling allows the purchase of a product with a known quality and the easy comparison of the product with other similar products of the market. N.J.A.C. 2:68-1.1 through 1.7 will continue to protect purchasers of feed commodities and pet foods by reducing the amount of misbranding and adding harmful ingredients to animal feeds.

Economic Impact

Consumers will realize economic savings through the accurate labeling. Manufacturers will be able to compete on an equal basis through the use of the same standards in formulating their labels. Economy of scale will be realized by the opening up of all markets in the United States to any commercial feed manufacturer through one uniform labeling system. The savings of these economies of scale will then be able to be passed on to the consumer. There is no increased cost on the Department of Agriculture by use of these standards.

Pursuant to N.J.S.A. 4:4-20.9, the manufacturers (or distributors) are charged a minimal fee for a license of $25.00/year and a tonnage fee of $0.15 per ton for product sold in New Jersey. This fee is a marketing cost which is passed on to the product consumer. This fee is given to the State Treasury. In the 1991-1992 period, 340 samples were analyzed in the laboratory and 4.7 percent were found to be deficient in protein and 3.2 percent had unsatisfactory fat contents.

Regulatory Flexibility Analysis

Some commercial feed manufacturers and distributors are small businesses, as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules proposed for readoption will have an economic impact on such businesses, though the Department knows of no less restrictive a system than expressed in the standards. No additional recordkeeping or reporting requirements are required under the rules.

The Association Standards are the most universal and accepted rules and provide a "level playing field" for all manufacturers. This should enable small businesses to compete against the larger businesses advertising budgets on the basis of the quality of the products.

Further, there is no way to protect the consumers of these products without a method of guaranteeing compliance with label claims. It is important that consumers be able to rely upon labeling which provides comparable information. It is not possible to exempt small businesses from compliance with these rules, due to an overriding concern for the

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public welfare. These standards are the most universally recognized, have been used by the Department for over 26 years, and provide the least costly and best protection available.

Full text of the proposed readoption may be found in the New Jersey Administrative code at N.J.A.C. 2:68.

Full text of the proposed amendment follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

2:68-1.1 General rules and regulations

(a) The Department of Agriculture adopts and incorporates by reference the general rules and regulations set forth in the current edition of the official publication of the Association of American Feed Control Officials, Inc.[1]

1.-10. (No change.)

[[1]Copy on file in Director's Office, Division of Regulatory Services, New Jersey Dept. of Agriculture: Health-Agriculture Bldg., John Fitch Plaza, Trenton, N.J. Copies may be procured by writing to Donald James, Dept. of Agriculture, Room E-111, State Capital Bldg., Charleston, West Virginia 25305.]

2:68-1.6 Sampling and analysis

Sampling and analysis shall be conducted in accordance with methods published in current edition of the official methods of analysis of the Association of Official Chemists[2] or in accordance with other recognized official methods.

[[2]Copy on file in Director's Office, Division of Regulatory Services, New Jersey Dept. of Agriculture: Health-Agriculture Bldg., John Fitch Plaza, Trenton, N.J. Copies may be obtained by writing to David MacLean, AOAC, 111 No. 19th St., Suite 210, Arlington, VA 22209.]

2:68-1.8 Obtaining copies of rules incorporated by reference

(a) A copy of the current edition of the Official Publication of the American Feed Control Officials is on file in the Director's Office, Division of Regulatory Services, New Jersey Department of Agriculture, Health & Agriculture Building, John Fitch Plaza, Trenton, New Jersey 08625. Copies may be procured by writing to Charles P. Rank, Georgia Department of Agriculture, Capital Square, Atlanta, Georgia 30334.

(b) A copy of the current edition of the official methods of the Association of Official Analytical Chemists (AOAC) is on file in the Director's Office, Division of Regulatory Services, New Jersey Department of Agriculture, Health & Agriculture Building, John Fitch Plaza, Trenton, New Jersey 08625. Copies may be procured by writing to AOAC, Fulfillment Coordinator, 2200 Wilson Boulevard, Arlington, Virginia 22201-3301.

(a)

STATE AGRICULTURE DEVELOPMENT COMMITTEE

Acquisition of Development Easements

Proposed Amendment: N.J.A.C. 2:76-6.11

Authorized By: State Agriculture Development Committee, Arthur R. Brown, Jr., Chairperson.

Authority: N.J.S.A. 4:1C-5f.

Proposal Number: PRN 1993-481.

Submit comments by October 7, 1993 to:
Donald D. Applegate, Executive Director
State Agriculture Development Committee
CN 330
Trenton, New Jersey 08625

The agency proposal follows:

Summary

At its meeting on June 24, 1993, the State Agriculture Development Committee, SADC reviewed public comments received in response to proposed amendments at N.J.A.C. 2:76-6.11, as published in the May 3, 1993, New Jersey Register at 25 N.J.R. 1804(a). Also see the adoption of related amendments in the August 2, 1993 New Jersey Register at 25 N.J.R. 3453(e).

In summary, the comments provided by counties and other individuals expressed positions of both support and opposition to the method for determining the SADC's percent cost share when providing a grant to a county for the purchase of a development easement. In view of the numerous responses and opposing positions, the SADC approved a new proposed amendment at N.J.A.C. 2:76-6.11 which is set forth below.

The proposed amendment at N.J.A.C. 2:76-6.11 directs the SADC to consider the landowner's formula index which is the method contained in the current rule and an alternative method which considers the landowner's asking price to establish its percent cost share. Furthermore, the proposed amendment provides that the SADC will determine its cost share percentage based on the higher of the two methods. Proposed N.J.A.C. 2:76-6.11(d)1ii also provides that the board may choose which of the two methods the SADC shall use to determine the percent cost share.

Other technical amendments at N.J.A.C. 2:76-6.11(b) and (d)1i are for the purpose of maintaining uniformity of terminology.

Social Impact

The proposed amendment will have a positive social impact by establishing a method for determining the SADC's cost share percentage which is acceptable to all counties participating in the Farmland Preservation Program.

The SADC recognizes that the continued purchase of development easements on farmland is critical to the agricultural industry in every county. The proposed amendment will provide counties with the incentive to continue to promote the purchase of development easements in their respective counties. The permanent protection of farmland benefits the general public by providing amenities such as local food source, an industry to promote employment, open space, water recharge and more.

Economic Impact

The proposed amendment will generally have a positive economic impact on counties participating in the Farmland Preservation Program due to the increase in State cost share grants.

The proposed amendment directs the SADC to provide counties with the higher cost share percentage resulting from the evaluation of two different methodologies. It was estimated that the alternative method considered under the proposed amendment would have increased the SADC's cost share percentage from 63.2 percent to 68.7 percent under the 1990/91 and 1991/92 development easement purchase rounds. This would have resulted in a $1.5 million increase in State cost share grants to counties. While it is conceded that a few counties would have received a reduction in State funding under the alternative method, the proposed amendment now directs the SADC to provide the higher cost share percentage resulting from the evaluation of the current method as well as the alternative method.

Regulatory Flexibility Analysis

The proposed amendment will primarily impact the 16 counties presently participating in the Farmland Preservation Program.

The proposed amendment directs the SADC to provide the higher of the cost share percentages determined by the evaluation of two different methods. At the county's discretion, it may specify which method the SADC should utilize to determine the cost share percentage.

The proposed amendments do not impose unduly burdensome recording, recordkeeping or compliance requirements on any small businesses, as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The compliance requirement as mandated by the proposed amendment is imposed on the SADC for determining its cost share percentage for providing a grant to the county for the purchase of development easements.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

2:76-6.11 Final committee review

(a) (No change.)

(b) Upon receipt of applications which have received final approval by the board, the Committee shall determine the landowner's formula index by application of the formula contained in N.J.S.A. 4:1C-31b(1) as follows:

$$\frac{\text{nonagricultural development value} - \text{agricultural value} - \text{[landowner] asking price}}{\text{nonagricultural development value} - \text{agricultural value}} = \text{formula index}$$

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(c) (No change.)

(d) The Committee shall not authorize a grant for an amount greater than 80 percent of the Committee's certified fair market value of the development easement.

1. The percent Committee cost share shall be based upon the [applicant's formula index as follows] **higher cost share percentage determined pursuant to the following two methods**:

The landowner's formula index method:

Landowner's formula index	Percent committee cost share
Less than 0.10	60
0.10 up to less than 0.20	65
0.20 up to less than 0.30	70
0.30 up to less than 0.40	75
0.40 or greater	80

(or)

The landowner's asking price method:

Landowner's asking price	**Percent committee cost share**
From $0 to $1,000	**80**
From > $1,000 to $3,000	**70**
From > $3,000 to $5,000	**60**
From > $5,000 to $10,000	**50**
From > $10,000 to $15,000	**25**
From > $15,000 to $20,000	**10**
From > $20,000	**0**

i. If the [landowner] **landowner's** asking price is greater than the certified fair market value, the Committee's cost share grant shall be based upon the Committee's certified fair market value.

ii. Notwithstanding (d)1 above, the board may choose which of the two methods the Committee shall use to determine the percent cost share.

2.-3. (No change.)

(e)-(f) (No change.)

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code Subcodes

Proposed Amendments: N.J.A.C. 5:23-2.6, 2.14, 2.23, 3.2, 3.4, 3.8A, 3.11A, 3.14, 3.15, 3.16, 3.17, 3.18, 3.20, 3.21, 4.3A, 4A.8, 4A.11 and 12.2

Proposed Repeal: N.J.A.C. 5:23-3.20A

Authorized By: Stephanie R. Bush, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 52:27D-124.

Proposal Number: PRN 1993-470.

Submit comments by October 7, 1993 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625
FAX No. (609) 633-6729

The agency proposal follows:

Summary

Section 5 of the State Uniform Construction Code Act, N.J.S.A. 52:27D-123, provides that "the initial adoption of a model code or standard as a subcode shall constitute adoption of any subsequent revisions or amendments thereto." However, when revisions or amendments are made to model codes, it is necessary for the Department to amend the appropriate sections of N.J.A.C. 5:23 so that cross-references will be correct. Accordingly, the Department is proposing these rule amendments in order to enable code enforcement officials, builders and property owners to use the 1993 editions of the BOCA National Building Code, the BOCA National Mechanical Code, the BOCA National Energy Conservation Code, the National Standard Plumbing Code and the National Electrical Code, and the 1992 edition of the CABO One and Two Family Dwelling Code.

These codes have been adopted by reference as the building, fire protection, mechanical, energy, plumbing, electrical and one- and two-family dwelling subcodes of the State Uniform Construction Code. The code writing organizations that sponsor these codes engage in a public code change process and issue succeeding editions of the codes. This enables the codes to respond to technological change. Modifications made to the new editions of the codes relate to the administration and enforcement procedures of the State Uniform Construction Code and do not alter the technical, substantive provisions of the model codes except to the extent that it is necessary to do so in order to make the adopted codes consistent with each other. Most of the changes made by this proposal simply recodify the requirements to parallel the recodifications made by the model codes.

Two significant new amendments have been made to the plumbing subcode at N.J.A.C. 5:23-3.15. One eliminates a conflict with the building subcode concerning subsoil drains by simply referring to the building subcode. The second eliminates the provisions dealing with abandonment of septic tanks, since these requirements are now contained in N.J.A.C. 7:9A (requirements for individual subsurface sewage disposal systems).

The electrical subcode at N.J.A.C. 5:23-3.16 has been modified to make it clear that it covers site lighting on private property, even if done by a public utility. This has been done by changing the explanatory material in FPN 90-2(b)(5) to text.

The energy subcode at N.J.A.C. 5:23-3.18 was amended to delete the section dealing with fixture flow rate values to eliminate conflicts with Chapter 7 of the plumbing subcode concerning lavatories and 1.6 gallon/flush water closets. Where possible, the numbers inserted in the blanks in Chapter 7 of the plumbing subcode are consistent with the numbers in Article 5 of the energy subcode.

The mechanical subcode at N.J.A.C. 5:23-3.20 is amended to retain Chapter 16, which was previously deleted. Since the ventilation rates in Chapter 16 are now consistent with the ventilation rates method in ASHRAE 62-89, deletion is no longer necessary and the adopted indoor air quality subcode is also no longer necessary. Therefore, the indoor air quality subcode, N.J.A.C. 5:23-3.20A, is repealed.

The one- and two-family dwellings subcode at N.J.A.C. 5:23-3.21 has been amended to make it clear that townhouses can be built under it. In addition, amendments have been made to this subcode to resolve discrepancies between it and the building subcode regarding handrails and smoke detectors. Finally, a new provision on reroofing has been added to the one- and two-family dwelling subcode in order to ensure consistency with the building subcode.

Social Impact

Adoption of the appropriate references to the most recent editions of the adopted subcodes will allow users of the State Uniform Construction Code to avoid confusion as to what code provisions are in effect and to benefit from the recent technological innovations upon which they are based.

Economic Impact

Correct cross-referencing, to the extent that it results in diminished uncertainty as to what is required, may be expected to reduce the chance that work will be done in reliance upon obsolete provisions and then have to be corrected at greater expense.

Regulatory Flexibility Statement

These proposed amendments, made to ensure that the administrative provisions of the State Uniform Construction Code remain consistent with the adopted subcodes, and that these subcodes remain consistent with each other, merely reflect changes already made by code writing organizations and in effect in New Jersey by operation of law. All businesses that are involved in any way with construction, regardless of size or form of organization, are equally subject to the State Uniform Construction Code and must remain so in order to maintain uniformly safe standards of building safety that are necessary in order to protect public health, safety and welfare.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

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5:23-2.6 Change in use group

(a)-(b) (No change.)

(c) Part change in use: If a portion of the structure is changed to a new use group, and that portion is separated from the remainder of the structure with the required vertical and horizontal fire [divisions] **separation assemblies** complying with the fire [grading] **resistance rating** in the building subcode, then **only** the construction involved in the change shall be made to conform **fully** to the requirements for the new use group [and], **while** the existing portion shall be made to comply **only** with the [exitway] **means of egress** requirements of the regulations.

5:23-2.14 Construction permits when required

(a) (No change.)

(b) The following are exceptions from (a) above:

1.-3. (No change.)

4. Permit requirements for tents and membraned structures shall be as set forth in N.J.A.C. 5:23-3.14(b)[5xii]**16i.** A temporary greenhouse meeting the criteria set forth in N.J.A.C. 5:23-3.14(b)[5xii(4)]**16i(4)** shall not require a permit except as otherwise provided in N.J.A.C. 5:23-3.14(b)[5xii(5)]**16i(5).**

5. (No change.)

(c)-(f) (No change.)

5:23-2.23 Certificate of Occupancy requirements

(a)-(f) (No change.)

(g) Contents of certificate: When a building or structure is entitled thereto, the construction official shall issue a certificate of [use and] occupancy within 10 business days after written application therefor.

1. The certificate shall certify the purpose for which the building or structure may be used in its several parts.

2. The certificate of occupancy shall specify: the use group(s), in accordance with the provisions of the building subcode; [the fire grading as defined in the building subcode;] the maximum live load on all floors as prescribed in the building subcode; the occupancy load in the building and all parts thereof as defined in the building subcode; and any special stipulations and conditions of the construction permit.

3. The construction official shall affix his signature [thereto,] **to the certificate** and, **by so doing,** shall [thereby] certify that the building or structure has been approved for occupancy by all applicable subcode officials in accordance with the provisions of [subchapter] **N.J.A.C. 5:23-**3 [below].

(h)-(l) (No change.)

5:23-3.2 Matters covered; exceptions

(a) (No change.)

(b) Rules concerning exceptions in health care facilities are as follows:

1. [Health] **Construction and alteration of health** care facilities shall be in accordance with this code and the standards imposed by the [United States Department of Health and Human Services (DHHS) and the] State Department of Health.[, and the department] **The Department**, specifically **adopts** the [DHHS] **"Guidelines for Construction and Equipment of Hospital**[s] **and Medical Facilities" 1992-93 edition or current edition (American Institute of Architects Committee on Architecture for Health), as amended by N.J.A.C. 8:43G,** [(DHHS Publication No. (HRS-M-HF) 84-1)] **as the uniform code of the State in all matters regulated by sections specified herein.** In order to avoid conflict, section [501.3] **503.3** [article 7 except section 713.0] of the building subcode of the New Jersey Uniform Construction Code shall not govern with respect to health care facilities. [The DHHS HRS-M-HF 84-1 shall serve as the Uniform Code of the State in all matters regulated by the sections herein specified.]

2. The Department of Health may adopt licensing standards for the physical plant and environment of health care facilities that supplement this code and the "Guidelines for Construction and Equipment of Hospital and Medical Facilities," although these standards may not be in conflict with these codes.

3. The publication "Guidelines for Construction and Equipment of Hospital and Medical Facilities" is available from The American Institute of Architects Press, 1735 New York Ave., N.W., Washington, D.C. 20006.

(c) (No change.)

(d) Commercial farm buildings shall be constructed in accordance with the following criteria:

1.-3. (No change.)

4. Construction, height and allowable area requirements for commercial farm buildings and structures shall be for one of the types of construction specified in the building subcode and shall not exceed the area or height limitations of Table [501] **503.**

i. (No change.)

5. Unlimited area farm buildings exempted under (d)4i above shall meet the following additional relaxed requirements in lieu of those requirements in [Article 8] **Chapter 10,** Means of Egress, of the BOCA **National** Building Code:

i. In lieu of the requirements of Section [807] **1006.0,** the maximum distance of travel from any point in the building to an exit shall not exceed 150 feet;

ii. In lieu of the requirements of Section [809] **1010.0,** one exit is required for each 15,000 square feet of floor area and fraction thereof;

iii. In lieu of the requirements of Section [823] **1023.0,** exit signs must be posted. Exit signs are not required to be illuminated;

iv. In lieu of the requirements of section [806] **1008.0,** occupancy is limited to 30 people;

v. Lightning protection of the type required for the structure by [NFPA 78] **NFiPA 780**, fire extinguishers and "no smoking" signs shall be provided;

vi. (No change.)

5:23-3.4 Responsibility

(a) Responsibility for enforcement of specific provisions of the building subcode shall be as follows:

1. Plan review functions of sections [513.0, 514.0, 601.0 through 604.0, 606.0, 607.0, 609.0 through 620.0 and 624.0 articles 8 and 9] **402.0 through 406.0, 408.0 through 420.0; Chapters 7, 8, and 10;** sections [2002.0, 2301.0, 2302.0 articles 24 and 25] **1506.0, 1511.0, 2603.0; section 2114.0, and Chapter 28;** sections [2606.0 through 2611.0] **3006.0 through 3011.0** for elevator devices not accessible to the general public in structures classified as Use Groups R-3, R-4, or in R-2 structures in which the elevator devices are wholly within dwelling units and not accessible to the general public, and [3018.0 and 3020.0] **3103.0, 3104.0, 3106.0, 3305.0 and 3406.0** shall be enforced jointly by the building subcode official and **the** fire protection subcode official.

i. Plan review functions of **sections** [2606.0 through 2611.0] **3006.0 through 3011.0** for elevator devices in any Use Group other than R-3, R-4, or in R-2 structures in which the elevator devices are wholly within dwelling units and not accessible to the general public, and for elevator devices that are accessible to the general public in structures classified as Use Groups R-2, R-3 or R-4, shall be enforced jointly by the building, elevator, and fire protection subcode officials.

2. Plan review functions of sections [605.0, 608.0, and 621.0 through 623.0] **407.0 and 421.0** shall be enforced exclusively by the building subcode official.

3. Plan review sections of [article 10] **Chapter 9** shall be enforced exclusively by the fire **protection** subcode official.

4. Construction inspection functions of sections [513.0, 601.0 through 601.8, 601.13 through 601.14.1, 601.14.3 through 624.0,] **402.0 through 402.9, 402.14 through 402.15.1, 402.15.3 through 421.0;** [articles 8 and 9] **Chapters 7, 8, and 10; and** sections [2002.0 and 2302.0; article 24; and sections 2607.1, 2607.2, 2607.4 through 2607.7, 2608.0, 2610.1 through 2610.2.1, 2610.2.3, 2610.4, 2611.1 and 2611.2] **1506.0, 1511.0, 2114.0, 2603.0, 3007.1, 3007.2, 3007.4 through 3007.7, 3008.0, 3010.1 through 3010.2.1, 3010.2.3, 3010.4, 3011.1, 3011.2, 3103.0 and 3104.0** shall be enforced exclusively by the building subcode official.

5. Construction inspection functions of sections [601.9 through 601.12] **402.10 through 402.13** and section[s 601.14.2,] **402.15.2,** [articles 10 and 25;] **Chapter 9 and Chapter 28;** and sections [2607.3,

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2610.2.2, 2611.2.1 and 2611.2.2, 3018.0 and 3020.0] **3007.3, 3010.2.2, 3011.2.1, 3011.2.2 and 3305.0** shall be enforced exclusively by the fire protection subcode official.

6. Construction inspection functions of sections [2606.0, 2609.0, 2610.3 and 2610.5] **3006.0, 3009.0, 3010.5 and 2010.5** shall be enforced exclusively by the elevator subcode official.

7. Section [2602.2] **3004.2** shall be enforced exclusively by the elevator subcode official.

8.-9. (No change.)

(b) (No change.)

(c) Responsibility for **the** enforcement of specific provisions of the electrical subcode shall be as follows:

1. (No change.)

2. Plan review functions of article 620 for elevator devices not accessible to the general public in structures classified as Use Group R-3, R-4, or in R-2 structures in which the elevator devices are wholly within dwelling units and not accessible to the general public, shall be enforced by the electrical subcode official.

i. Plan review functions of article 620 for elevator devices in any Use Group other than R-3, R-4, or in R-2 structures in which the elevator devices are wholly within dwelling units and not accessible to the general public, and for elevator devices that are accessible to the general public in structures classified as Use Groups R-2, R-3 or R-4, shall be enforced jointly by the elevator and electrical subcode officials.

Recodify existing 2. as **3.** (No change in text.)

4. Construction inspection functions of article 620 for entire parts A, B, E and H, and of part C (except section 620-22), part D (except section 620-38), section 620-51(b) of Part F, part J (except section 620-85), and part K (except section 620-101(b), for elevator devices in any Use Group other than R-3, R-4, or in R-2 structures in which the elevator devices are wholly within dwelling units and not accessible to the general public shall be enforced exclusively by the elevator subcode official.

i. For elevator devices not accessible to the general public in structures classified as Use Group R-3, R-4, or in R-2 structures in which the elevator devices are wholly within dwelling units and not accessible to the general public, construction inspection functions of article 620 in its entirety shall be the sole responsibility of the electrical subcode official.

5. Construction inspection functions of sections 620-22, 620-38 (for electrical equipment and materials only), part F (except section 620-51(b), entire part G, Section 620-85 and section 620-101(b), shall be enforced exclusively by the electrical subcode official.

Recodify existing 3.-4. as **6.-7.** (No change in text.)

(d) (No change.)

(e) Responsibility for enforcement of specific provisions of the energy subcode shall be as follows:

1. [Articles] **Chapters** 3 and 4 shall be enforced exclusively by the building subcode official.

2. [Article] **Chapter** 5 shall be enforced exclusively by the plumbing subcode official.

3. [Article] **Chapter** 6 and standard LEM-1 shall be enforced exclusively by the electrical subcode official.

4. Plan review and construction inspection functions for structures submitted under [Article] **Chapter** 7 shall be reserved to the respective subcode officials as delineated above.

5. (No change.)

(f) Responsibility for enforcement of specific provisions of the [Mechanical Subcode] **mechanical subcode** shall be as follows:

1. [Articles] **Chapters 3,** 12 and 14 and sections [M-301 through M-311, M-900, M-901.3, M-903.1, M-903.3, M-903.4, M-906 and M-908] **M-901.0, M-903.3, M-905.1, M-905.3, M-905.4, M-908.0 and M-910.0:** Plan review functions shall be enforced jointly by the building and fire protection subcode officials. Construction inspection functions shall be enforced exclusively by the Building subcode official.

2. [Articles] **Chapters** 4, 5, and 10**:** Plan review and construction inspection functions shall be enforced exclusively by the fire **protection** subcode official.

3. [Articles] **Chapters** 6, 7, 8 and 13 and sections [M-901.1, M-901.2, M-901.4 through M-901.9, M-902, M-903.2, M-904, M-905, M-907, M-909 and M-910] **M-903.1, M-903.2, M-903.4 through M-903.9, M-904.0, M-905.2, M-906.0, M-909.0, M-911.0 and M-912.0:** Plan review and construction inspection functions shall be enforced exclusively by the plumbing subcode official.

4. [Article] **Chapter** 11 [and section M-312]: Plan review functions shall be enforced jointly by the building and fire protection subcode officials; construction inspection functions shall be enforced exclusively by the fire protection subcode official.

5. [Article] **Chapter** 15**:** Plan review functions shall be enforced by the Department of Community Affairs, and construction inspection functions shall be enforced by the fire **protection** subcode official.

6. [Article] **Chapter** 16**:** Plan review and construction inspection functions shall be enforced exclusively by the building subcode official.

7. [Article] **Chapter** 18**:** Plan review functions shall be enforced jointly by the building and plumbing subcode officials; construction inspection functions shall be enforced by the plumbing subcode official.

[(g) Responsibility for enforcement of the indoor air quality subcode shall be the exclusive province of the building subcode official, except as otherwise specified in N.J.A.C. 5:23-3.11(h).]

Recodify existing (h)-(j) as **(g)-(i)** (No change in text.)

5:23-3.8A Products violating the Code

(a)-(b) (No change.)

(c) Any person who, having received a notice of violation pursuant to this section, continues to sell or offer for retail sale products specified in such notice, shall be deemed to be knowingly selling or offering the product for sale in violation of the Code and shall be subject to penalty as provided by statute, in accordance with the procedures set forth in N.J.A.C. 5:23-[23.31]**2.31.**

(d) The Commissioner has determined that the following materials and supplies are not in conformance with the State Uniform Construction Code:

1. Building materials and supplies:

i. Wood paneling being used as an interior finish not in conformance with section [903.2] **803.2** of the building subcode. This section specifies that finish shall be classified in accordance with ASTM E84;

ii. Carpeting used as an interior floor finish material not in conformance with section [903.3] **805.2** of the building subcode. This section specifies that interior floor finish shall be classified in accordance with ASTM E648; and

[iii. Water closets requiring in excess of an average of 1.6 gallons per flush, that either have a manufacturer's date stamp of July 1, 1991 or later or were not purchased by the distributor prior to July 1, 1991.]

2. (No change.)

3. Plumbing materials/supplies:

i.-iv. (No change.)

v. Water closets requiring in excess of an average of 1.6 gallons per flush, that either have a manufacturer's date stamp of July 1, 1991 or later or were not purchased by the distributor prior to July 1, 1991.

4. (No change.)

5:23-3.11A Enforcement activities reserved to other State agencies

(a)-(d) (No change.)

(e) The State Department of Education, or the municipal code enforcing agency providing construction code plan approval, shall be responsible for enforcing the following Uniform Construction Code enhancements in public school buildings:

1.-4. (No change.)

5. An automatic fire detection system shall be installed in all new buildings of use group E (educational), as designated in the BOCA National Building Code/[90] **93** Section [1016.4.1] **917.4.1** and in accordance with applicable National Fire Protection Association standards. The system shall utilize:

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i. Combination fixed-temperature and Rate of Rise devices in classrooms and other spaces not covered in [(d)5ii] **(e)5ii** below;

ii.-iv. (No change.)

6. Manual fire alarm boxes, in addition to BOCA/[90] **93** Section [1016.3] **917.5** requirements as amended, shall be provided in the natural path of escape from fire, near each exterior door from the corridor, kitchen, heater room and other exterior exits that are required to serve 50 or more persons. Additional fire alarm boxes shall be located in the main office, stage, at each stairway entrance from a corridor or place of assembly and near one exterior exit in each section of a place of assembly. It shall not be necessary to traverse more than 200 feet of unobstructed horizontal distance on the same floor in order to reach a fire alarm box.

7.-8. (No change.)

5:23-3.14 Building subcode

(a) Rules concerning the building subcode adopted are as follows:

1. Pursuant to authority of P.L.1975, c.217, the Commissioner hereby adopts the model code of the Building Officials and Code Administrators International, Inc., known as the "BOCA National Building Code/[1990] **1993**," including all subsequent revisions and amendments thereto. This code is hereby adopted by reference as the building subcode for New Jersey subject to the modifications stated in (b) below.

i. (No change.)

ii. "The BOCA National Building Code/[1990] **1993**," including all subsequent revisions and amendments thereto, may be known and cited as the "building subcode."

2. Any references to the mechanical code, plumbing code, CABO One and Two Family Dwelling Code, **CABO A117.1 standard (including reference to chapter 11)** or NFiPA 70 (including reference to [Article] **Chapter** 27) listed in [Appendix A] **Chapter 35** shall be considered a reference to the appropriate adopted mechanical, plumbing, one and two family dwelling or electrical subcode **referenced** in N.J.A.C. 5:23-3 **or to the barrier-free subcode, N.J.A.C. 5:23-7, as appropriate.**

[3. The 1991 Supplement to the BOCA National Building Code/ 1990 is adopted by reference with modifications as cited in (c) below as part of the building subcode for New Jersey.]

(b) [Articles or sections] **The following chapters** of the **building** subcode are modified as follows:

1. [Article] **Chapter** 1 of the building subcode, entitled "Administration [and Enforcement]," is deleted in its entirety.

[2. The following amendments are made to article 2 of the building subcode, entitled "Definitions," section 201.0—general definitions.

i. From the definition of the term "addition", delete the reference "see Section 103.3";

ii. From the definition of the term "alteration" delete the reference "see Section 103.3";

iii. The definition of the term "approved" is amended to add the phrase "in accordance with the regulations" after the word "jurisdiction" on line 2;

iv. The definition of the term "approved agency" is amended to add the phrase "by the code official or other authority having jurisdiction in accordance with the regulations" at the end;

v. The term and definition of "approved material, equipment and methods" is deleted;

vi. The term and the definition of "approved rules" is deleted;

vii. The definition of the term "building" is deleted and substitute in lieu thereof, the definition of "building" found in N.J.A.C. 5:23-1.4;

viii. The term and the definition of "certificate of use and occupancy" is deleted;

ix. The term and the definition of "change of use" is deleted;

x. The definition of the term "code official" is deleted and is redefined herein and throughout the subcode as the "building subcode official" as defined in N.J.A.C. 5:23-1.4 unless indicated otherwise;

xi. The term and the definition of "Degree day, heating" is deleted;

xii. The definition of the term "dwellings-boarding house" is deleted, and substitute in lieu thereof, the definition of the term "boarding house" found in N.J.S.A. 55:13B-3;

xiii. The term and definition of "exterior envelope" is deleted;

xiv. The term and the definition of "inspection, special" is deleted;

xv. The term and definition of "mobile unit" is deleted. Substitute in lieu thereof the term and definition of "manufactured home" found in N.J.A.C. 55:23-1.4;

xvi. The definition of the term "owner" is deleted, and in lieu thereof, substitute the definition found in N.J.A.C. 5:23-1.4;

xvii. From the definition of the term "permit", delete the reference "see Section 112.0";

xviii. The term and the definition of "positive heat supply" is deleted.

xix. The term and the definition of "posted use and occupancy" is deleted.

xx. From the definition of the term "professional engineer or architect", delete the reference "see Section 108.0";

xxi. The term and the definition of "Thermal resistance (R)" is deleted;

xxii. The term and the definition of "Thermal transmittance (U)" is deleted;

xxiii. The term and the definition of "Thermal transmittance (Uo)" is deleted.]

2. The following amendments are made to Chapter 2 of the building subcode, entitled "Definitions," section 202.0 general definitions:

i. The term and definition of "Additions" is deleted;

ii. The definition of the term "Approved" is amended to delete the phrase "or other authority";

iii. The phrase and definition of "Approved material, equipment and methods" is deleted;

iv. The term and definition of "Approved rules" is deleted;

v. The definition of the term "Building" is deleted and replaced by the definition at N.J.A.C. 5:23-1.4;

vi. The term and definition of "Building, existing" is deleted;

vii. The term and definition of "Building line" is deleted;

viii. The term and definition of "Building service equipment" is deleted and replaced by the term and definition of "equipment" at N.J.A.C. 5:23-1.4;

ix. The definition of the term "Code official" is deleted and is redefined herein and throughout the subcode as the "building subcode official" as defined in N.J.A.C. 5:23-1.4 unless indicated otherwise;

x. The term and definition of "Construction documents" is deleted;

xi. The term and definition of "Equipment, existing" is deleted;

xii. The term and definition of "Facility" is deleted;

xiii. The terms and definitions of "hereafter" and "heretofore" are deleted;

xiv. The term and definition of "Jurisdiction" is deleted;

xv. The term and definition of "Occupancy, change of" is deleted;

xvi. The definition of "Owner" is deleted and replaced by the definition at N.J.A.C. 5:23-1.4;

xvii. The term and definition of "Permit" is deleted;

xviii. The term and definition of "Person" is deleted;

xix. The reference for "Physically Disabled Person" is deleted and replaced with the definition of "Physically Handicapped" at N.J.A.C. 5:23-7;

xx. The term and definition of "Repair" is deleted;

xxi. The term and reference for "Site" is deleted;

xxii. The definition of the term "Structure" is replaced by the definition at N.J.A.C. 5:23-1.4;

xxiii. The term and definition "Structure, existing" is deleted;

xxiv. The term and reference for "Technically Infeasible" is deleted;

xxv. The term and definition of "Writing" is deleted;

xxvi. The term and definition of "Zoning" is deleted.

3. The following amendment[s are] **is** made to [article] **Chapter** 3 of the building subcode entitled "Use [Group Classification] **or Occupancy**."

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i. Section [309.5] **310.6** is amended to delete the phrase "not more than three stories in height [on line 2]."

[4. The following amendments are made to Article 5 of the building subcode entitled "General Building Limitations."

i. Section 505.0 is deleted in its entirety;

ii. Section 506.5 is deleted in its entirety;

iii. Section 510.1 is amended to delete the phrase "code official" on line 1 and substitute in lieu thereof, "construction official";

iv. Section 511.1 is amended to read as follows: "The construction official may issue a permit for temporary construction. Such permits shall be limited as to time of service, but such temporary construction shall not be permitted for more than one year";

v. Section 511.3 is amended to read as follows: "The construction official is hereby authorized to cancel such special approval and to order the demolition of any such construction when any permit conditions have been violated";

vi. Section 512.0 is deleted in its entirety;

vii. Section 513.1 is amended to delete the phrase "subject to the approval of the board of appeals" on line 5. Further, section 513.1 is amended to delete the phrase "code official" and substitute in lieu thereof "construction official";

viii. Section 514.5 is amended to delete the term "authorities" and substitute in lieu thereof "authorities having jurisdiction."]

4. The following amendments are made to Chapter 4 of the building subcode, entitled "Special Use and Occupancy":

i. Section 415.1 is amended to replace the phrase "authority having jurisdiction" with the term "construction official";

ii. Section 416.11 is deleted;

iii. Section 420.0 is amended to replace the terms "Mobile Units," "Unit" and "Units" with the terms "Manufactured Homes," "Home" and "Homes" respectively;

iv. Sections 420.1 and 420.2 are deleted in their entirety;

v. Section 421.3 is amended to replace the term "code official" with the term "construction official";

vi. Section 421.6 is amended to end with the phrase "in accordance with the plumbing subcode";

vii. Section 421.6.1 is deleted;

viii. Section 421.6.2 is amended to end with the phrase "in accordance with the plumbing subcode";

ix. Section 421.9.3 is amended to replace the term "governing body" with the term "construction official."

[5. The following amendments are made to Article 6 of the building subcode, entitled "Special Use and Occupancy Requirements":

i. Section 600.2 is amended to delete the phrase "authority having jurisdiction" and substitute in lieu thereof "construction official";

ii. Section 602.2 "Maintenance and Inspection" is deleted in its entirety;

iii. Section 620.0 is amended to delete the phrase "mobile units" and substitute in lieu thereof "manufactured homes";

iv. Sections 620.1 and 620.2 are deleted in their entirety;

v. Sections 620.3 and 620.3.1 are amended to delete the words "mobile units," "unit" and "units" and substitute in lieu thereof "manufactured homes," "home" and "homes";

vi. Section 621.5 is amended to add the phrase "to comply with the requirements of the electrical subcode" after the word "grounded";

vii. Section 623.3 is amended to delete the phrase "code official" and substitute in lieu thereof "construction official";

viii. Section 623.6 is amended to end with the phrase "in accordance with the plumbing subcode";

ix. Section 623.6.1 is deleted;

x. Section 623.6.2 is amended to end with the phrase "in accordance with the plumbing subcode";

xi. Section 623.9 is amended to delete the phrase "governing body" and substitute in lieu thereof "construction official";

xii. Section 624.1.1 is deleted in its entirety and the following language is substituted in lieu thereof:

(1) Temporary structures: A construction permit is required for the erection, operation or maintenance of all temporary structures (excluding tents and tensioned membrane structures) covering an area in excess of 120 square feet, including all connecting areas or spaces with a common means of egress or entrance, or which are used or intended to be used for gatherings of 10 or more persons;

(2) Tents with appurtenances: A construction permit is required for the erection, operation or maintenance of all tents or tensioned membrane structures of any size if they contain appurtenances such as platforms or electrical equipment;

(3) Tents without appurtenances: No construction permit is required for the erection, operation or maintenance of any tent or tensioned membrane without appurtenances. If the tent or structure is more than 900 square feet in area or more than 30 feet in any dimension (excluding canopies), whether it is one unit or composed of multiple units, the requirements of the Uniform Fire Code, N.J.A.C. 5:18, shall be enforced by the appropriate officials. Tents used exclusively for recreational camping purposes shall be exempt from construction permit requirements.

(4) A temporary greenhouse, also called a "hoophouse" or "polyhouse," used exclusively for the production or storage of live plants, shall be exempt from the permit requirements of the Uniform Construction Code if it meets the following criteria:

(A) There is no permanent anchoring system or foundation;

(B) There is no storage, temporary or otherwise, of solvents, fertilizers, gases or other chemical or flammable materials;

(C) The structure is no wider than 31 feet and there is an unobstructed path of no greater length than 150 feet from any point to a door or fully accessible wall area; and

(D) The covering of the structure is of a material no greater than six mils (152.4 micrometers) in thickness, conforming to N.F.P.A. 701 standard, that yields approximately four pounds of maximum impact resistance to provide egress through the wall.

(5) The provisions of (b)5xii(4) above notwithstanding, if a temporary greenhouse contains any device subject to the electrical subcode or any mechanical equipment subject to the mechanical subcode, then a permit shall be required for the system or fixture only. If the temporary greenhouse is connected to a potable water system, a permit shall be required for the backflow prevention devices only.

xiii. Section 624.6 is amended to delete the phrase "code official" and substitute in lieu thereof "construction official."]

5. The following amendment is made to Chapter 8 of the building subcode, entitled "Interior Finishes":

i. Sections 805.2.1 and 807.2.2 are amended to replace the term "code official" with the term "fire protection subcode official."

[6. The following changes are made to Article 7 of the building subcode entitled "Interior Environmental Requirements."

i. Section 702.0 is deleted in its entirety;

ii. Section 711.1 is amended to delete the phrase "of the minimum dimensions herein prescribed";

iii. Section 711.1.1 and 711.1.2 are deleted in their entirety.]

6. The following amendments are made to Chapter 9 of the building subcode, entitled "Fire Protection Systems":

i. References to the term "code official" shall be replaced with the term "fire protection subcode official."

ii. Section 901.4 is deleted in its entirety;

iii. Section 903.1 is amended to replace the term "department" with the phrase "enforcement agency responsible for plan review," and in the note, to replace the word "Since" with the term "If";

iv. Section 916.0 is amended to replace the phrase "administrative authority of the jurisdiction" with the term "fire protection subcode official";

[7. The following amendments are made to Article 8 of the building subcode entitled "Means of Egress."

i. Section 800.1 is amended to delete the sentence "Existing buildings and uses shall be controlled by the provisions of section 804.0";

ii. Section 800.2 is amended to delete the phrase "article 1 for modification of this code, or by adoption of approved rules" and in lieu thereof, substitute "N.J.A.C. 5:23-2";

iii. Section 803.7, Exception, is amended to delete the phrase "Section 512.0" and substitute in lieu thereof "the Barrier-Free Subcode";

iv. Section 804.0 is deleted in its entirety;

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v. Sections 813.4, 813.4.1.2 and 813.4.2 are amended to delete the phrase "15-pounds (73N)" and substitute in lieu thereof "8-pounds (39N)";

vi. Section 816.3 is amended to delete the phrase "the physically handicapped . . . otherwise" and substitute in lieu thereof "Barrier-Free accessibility shall be in accordance with the Barrier-Free Subcode";

vii. Section 816.4 is amended to delete the second sentence and substitute in lieu thereof "Barrier-Free accessibility shall be in accordance with the Barrier-Free Subcode";

viii. Section 816.5 is amended to delete the third sentence and substitute in lieu thereof "Barrier-Free accessibility shall be in accordance with the Barrier-Free Subcode."]

7. The following amendment is made to Chapter 10 entitled "Means of Egress":

i. Section 1001.2 is amended to replace the phrase "Article 1 for modification of this code or by adoption of approved rules" with the regulations at "N.J.A.C. 5:23-2";

8. The following amendments are made to [Article 9] **Chapter 11** of the building subcode, entitled ["Fireresistive Construction."] **"Accessibility"**:

i. [Sections 903.4.3 and 922.8.2 are amended to delete the phrase "code official" and substitute in lieu thereof "fire protection subcode official."] **Chapter 11 is deleted in its entirety and replaced with the accessibility requirements contained in N.J.A.C. 5:23-7.**

[9. The following amendments are made to Article 10 of the building subcode, entitled "Fire Protection Systems":

i. Section 1000.3 is amended to delete the phrase "code official" and substitute in lieu thereof "fire protection subcode official";

ii. Sections 1000.7 and 1000.8 are amended to delete the phrase "code official" and substitute in lieu thereof "fire protection subcode official";

iii. Section 1001.1 is amended to replace the term "department" with the phrase "enforcement agency responsible for plan review," and, in the note, to replace the term "Since" with the term "If";

iv. Section 1001.2 is amended to replace the term "department" with the phrase "enforcement agency responsible for plan review";

v. Section 1014.3 is amended to delete the term "fire department" on line 2, and substitute in lieu thereof the phrase "fire protection subcode official";

vi. Section 1015.1 is amended to delete the phrase "administrative authority of this jurisdiction" and substitute in lieu thereof "fire protection subcode official";

vii. Section 1017.3 is amended to delete the words "new and existing" in the first line;

viii. Section 1016.7.4 is amended to delete the term "code official" on line 2 and substitute in lieu thereof, "fire protection subcode official";

ix. Section 1019.1.3 is deleted in its entirety;

x. Section 1019.2.3 is amended to delete the phrase "code official" and substitute in lieu thereof "Fire Protection Subcode Official";

xi. Section 1019.4.4 is amended to delete the phrase "fire department" on lines 6 and 7 and substitute in lieu thereof "fire protection subcode official."]

9. The following amendment is made to Chapter 13 entitled "Energy Conservation":

i. Chapter 13 is deleted in its entirety.

[10. The following amendments are made to Article 13 of the building subcode entitled "Materials and Tests":

i. Section 1300.2 is amended to delete the term "approved rules" and substitute in lieu thereof "regulations";

ii. Section 1302.1 is amended to replace the phrase "approved rules" with the word "regulations" and to replace the phrase "Section 110.0" with the phrase, "the regulations";

iii. Section 1303.1 is amended to delete the phrase "and the approved procedures" on lines 7 and 8;

iv. Section 1305.1 is amended to delete the phrase "the approved rules" on line 5 and substitute in lieu thereof, "the regulations";

v. Section 1308.1 is amended to add the phrase "for Class I structures or when requested by the building subcode official" after the word "special inspections" on the first line;

vi. Section 1308.1.1 is deleted in its entirety and substitute in lieu thereof "Permit applications shall be made in accordance with N.J.A.C. 5:23-2.15.";

vii. Section 1308.2 is deleted and substitute in lieu thereof "Premanufactured construction and components shall be approved in accordance with N.J.A.C. 5:23-4.26.";

viii. Section 1308.3.1 is deleted in its entirety.]

10. The following amendment is made to Chapter 15 of the building subcode, entitled "Roofs and Roof Structures":

i. Section 1512.1 is amended to delete the sentence "The repairs . . . . for new roofing."

[11. The following amendments are made to Article 21 of the building subcode, entitled "Exterior Walls":

i. Section 2101.6.7 is amended to delete the phrase "mobile units" and substitute in lieu thereof "manufactured homes";

ii. Section 2101.6.9 is deleted in its entirety;

iii. Section 2101.6.10 is deleted in its entirety.]

11. The following amendments are made to Chapter 17 of the building subcode, entitled "Structural Tests and Inspections":

i. Section 1701.2 is amended to replace the term "approved rules" with the word "regulations";

ii. Section 1702.1, the definition of the term "approved agency" is amended to add the words "by the code official or other authority having jurisdiction in accordance with the regulations" after the word "approved";

iii. Section 1702.1, the definition and the term "Inspection, special" are deleted;

iv. Section 1705.1 is amended to add the words "for Class 1 structures when requested by the building subcode official" after the words "special inspections" on lines 1 and 2;

v. Section 1705.1.1 is deleted in its entirety and replaced with the sentence: "Permit applications shall be made in accordance with N.J.A.C. 5:23-2.15";

vi. Section 1705.2 is amended to add the sentence: "Building elements fabricated off site shall be approved in accordance with N.J.A.C. 5:23-4.26";

vii. Section 1705.3.1 is deleted in its entirety;

viii. Section 1707.1 is amended to replace the phrase "approved rules" with the word "regulations," and to replace the phrase "Section 106.0" with the phrase "the regulations."

[12. The following amendments are made to Article 23 of the building subcode, entitled "Roofs and Roof Coverings":

i. Section 2308.1 is amended to delete the phrase "The repair . . . for new roofing."]

12. The following amendment is made to Chapter 27 of the building subcode, entitled "Electric Wiring, Equipment and Systems":

i. Chapter 27 is deleted in its entirety.

13. The following amendments are made to [Article 25] **Chapter 28** of the building subcode, entitled "Mechanical [Equipment and] Systems":

i. Section [2503.0] **2803.0** is deleted in its entirety;

ii. Section [2504.0] **2811.0** is deleted in its entirety;

[14. The following amendments are made to Article 26 of the building subcode, entitled "Elevators, Dumbwaiter and Conveyor Equipment, Installation and Maintenance":

i. Section 2600.1 is amended to delete the phrase "Except as otherwise provided by statute" in the first line, to add the words "and subchapter 12 of these rules" after the word "article" in the first sentence, to delete the phrase "and amusement devices" from the second sentence and to substitute "construction official" for "code official."

ii. Section 2600.2 is amended to substitute "these rules" for "this code" and the following sentence is added: "However, any education, experience or training requirements included or cited in reference standards shall not be binding in this State.";

iii. Sections 2601.1, 2601.2, 2601.3, 2602.5.4, 2603.1, 2603.2 (first line), 2603.3, 2604.4, 2604.5 and 2604.6 are amended to delete the term "code official" and substitute in lieu thereof "construction official";

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iv. Section 2602.1 is amended to delete the words "and maintenance" and "and periodic inspections" in the second line;

v. Section 2602.2 is amended to delete the words "Section 2602.5" in the last sentence and to substitute in lieu thereof the words "N.J.A.C. 5:23-12" and to delete the words "code official" in the last sentence and substitute in lieu thereof "appropriate subcode official as designated by N.J.A.C. 5:23-3.4";

vi. Sections 2602.3, 2602.4 and 2602.5 are deleted in their entirety;

vii. Section 2603.2 is amended to delete the words "code official" in the second sentence and substitute in lieu thereof "appropriate subcode official as designated by N.J.A.C. 5:23-3.4". Further, section 2603.2 is amended to delete the word "made" in the last sentence and substitute in lieu thereof, the words "will make";

viii. Section 2604.3 is deleted in its entirety.

ix. Section 2604.4 is amended to delete the phrase "or not in accordance with the provisions of this code" on lines 2 and 3;

x. Section 2605.0 is deleted in its entirety;

xi. Section 2606.3 is amended to delete the phrase "ANSI A117.1 listed in Appendix A" and substitute in lieu thereof "the Barrier-Free subcode";

xii. Section 2610.2.2 is amended to delete the phrase "code official" and substitute in lieu thereof "fire protection subcode official".]

14. The following amendment is made to Chapter 29 of the building subcode, entitled "Plumbing Systems":

i. Chapter 29 is deleted in its entirety.

[15. The following amendments are made to Article 27 of the building subcode entitled "Electrical Wiring, Equipment and Systems":

i. Article 27 is deleted in its entirety.]

15. The following amendments are made to Chapter 30 of the building subcode, entitled "Elevators and Conveying Systems":

i. Section 3001.1 is amended to delete the phrase "Except as otherwise provided by statute" in the first line, to add the phrase "and where applicable, of N.J.A.C. 5:23-12" after the word "Chapter" in the second line, to delete the phrase "and amusement devices" in the second sentence and to replace the term "code official" with the term "construction official" in the second sentence;

ii. Section 3001.2 is amended to substitute the term "this code" for "these rules" and to add the following sentence: "However any education, experience or training requirements included or cited in reference standards shall not be binding in this State.";

iii. Section 3003.0 is deleted in its entirety except section 3003.3;

iv. Section 3004.1 is amended to delete the words "and maintenance" and substitute in lieu thereof "inspection and," and to delete the words "and periodic inspections";

v. Section 3004.2 is amended to add the words "inspection and" after the word "Acceptance" in the title and after the words "All such" in the seventh line; to delete the words "this code" in the first sentence and substitute in lieu thereof "these rules"; and to replace the term "code official" with the term "appropriate subcode official";

vi. Sections 3004.3 and 3004.4 are deleted in their entirety;

vii. Section 3004.5.2 is amended to delete the words "and amusement devices" and to add the word "and" after the word "freight lifts" in this section;

viii. Section 3004.5.4 is amended to replace the term "code official" with the term "construction official";

ix. Section 3005.0 is deleted in its entirety with the exception of section 3005.4 which is amended to replace the term "code official" with the term "construction official";

x. Section 3009.0 is amended to delete the words "Signals and" after the word "Emergency" in the title;

xi. Section 3010.2.2 is amended to replace the term "code official" with the term "fire protection subcode official";

xii. Section 3012.2 is deleted;

xiii. Section 3012.4 is amended to replace the term "code official" with the term "construction official";

xiv. Section 3012.5 is amended to replace the term "code official" with the term "construction official";

xv. Section 3013.0 is deleted in its entirety.

[16. The following amendments are made to Article 28 of the building subcode entitled "Plumbing Systems":

i. Article 28 is deleted in its entirety.]

16. The following amendments are made to Chapter 31 of the building subcode, entitled "Special Construction":

i. Section 3104.1.1 is deleted in its entirety and replaced by the following language:

(1) Temporary structures: A construction permit is required for the erection, operation or maintenance of all temporary structures (excluding tents and tensioned membrane structures) covering an area in excess of 120 square feet, including all connecting areas or spaces with a common means of egress or entrance, or which are used or intended to be used for gatherings of 10 or more persons;

(2) Tents with appurtenances: A construction permit is required for the erection, operation or maintenance of all tents or tensioned membrane structures of any size if they contain appurtenances such as platforms or electrical equipment;

(3) Tents without appurtenances: No permit is required for the erection, operation or maintenance of any tent or tensioned membrane structure without appurtenances if the tent or structure is no more than 900 square feet in area and no more than 30 feet in any dimension (excluding canopies), whether it is one unit or composed of multiple units. Tents used exclusively for recreational camping purposes shall be exempt from the above requirements.

(4) A temporary greenhouse, also called a "hoophouse" or "polyhouse," used exclusively for the production or storage of live plants, shall be exempt from the permit requirements of the Uniform Construction Code if it meets the following criteria:

(A) There is no permanent anchoring system or foundation;

(B) There is no storage, temporary or otherwise, of solvents, fertilizers, gases, or other chemical or flammable materials;

(C) The structure is no wider than 31 feet and there is an unobstructed path of no greater length than 150 feet from any point to a door or fully accessible wall area; and

(D) The covering of the structure is of a material no greater than six mils (152.4 micrometers) in thickness, conforming to N.F.P.A. 701 standard, that yields approximately four pounds of maximum impact resistance to provide egress through the wall.

(5) The provisions of (b)16i(4) above notwithstanding, if a temporary greenhouse contains any device subject to the electrical subcode or any mechanical equipment subject to the mechanical subcode, then a permit shall be required for the system or fixture only. If the temporary greenhouse is connected to a potable water system, a permit shall be required for the backflow prevention devices only;

ii. Section 3104.6 is amended to replace the term "code official" with the term "construction official";

iii. Section 3106.5 is amended to replace the term "authorities" with "authorities having jurisdiction";

iv. Section 3108.5 is amended to add the phrase "to comply with the requirements of the electrical subcode" after the word "grounded."

[17. The following amendments are made to Article 29 of the building subcode entitled "Signs":

i. Section 2901.1 is amended to delete the term "code official" and substitute in lieu thereof, "construction official";

ii. Section 2901.2 is amended to delete the phrase "code official and the required bond ... Section 2906.0" and substitute in lieu thereof "construction official";

iii. Section 2901.3 is amended to delete the phrase "code official" and substitute in lieu thereof, "construction official";

iv. Section 2903.1 is amended to delete the reference to "section 121.0" and substitute in lieu thereof, "N.J.A.C. 5:23-2.32";

v. Section 2906.0 is deleted in its entirety.]

17. The following amendments are made to Chapter 32 of the building subcode, entitled "Construction in the Public Right of Way":

i. Section 3202.5 is deleted in its entirety.

ii. Section 3205.1 is amended to replace the term "code official" on line 1 with the term "construction official".

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18. The following amendments are made to [Article 30] **Chapter 33** of the building subcode, entitled ["Precautions During Building Operations".] **"Sitework, Demolition and Construction":**

i. Section [3003.2 is amended to delete the reference to "sections 121.0 and 123.0" and substitute in lieu thereof "N.J.A.C. 5:23-2.32"] **3302.1 is amended to replace the term "code official" on line 3 with the term "construction official";**

ii. Section [3005.2] **3309.2** is amended to delete the words "and the construction and extension of soil and vent stacks and the location of window openings shall [conform to] **comply with** the provisions of section [2805.4" and substitute in lieu thereof,] **2908.3" and replace them with** the following language:

(1)-(2) (No change.)

iii. Section [3022.1 is amended to delete the phrase "code official" and substitute in lieu thereof] **3310.3 is amended to replace the term "code official" on lines 1 and 4 with the term** "construction official".

[19. The following amendments are made to Article 31 of the building subcode entitled "Energy Conservation":

i. Article 31 is deleted in its entirety.]

19. The following amendment is made to Chapter 34 entitled "Existing Structures":

i. Chapter 34 is deleted with the exception of section 3406.0, which is amended to replace the term "code official" with the term "construction official";

[20. The following amendments are made to Article 32 of the building subcode entitled "Repair, Alteration, Addition and Change of Use of Existing Buildings":

i. Article 32 is deleted in its entirety.]

[21.]**20.** The following amendments are made to [Appendix A] **Chapter 35** of the building subcode, entitled "Referenced Standards":

i.-iii. (No change.)

[(c) These articles or sections of the 1991 Supplement to the building subcode are modified as follows:

1. Article 1 of the building subcode, entitled "Administration and Enforcement":

i. Section 119.0 is deleted.

2. Article 2 of the building subcode, entitled "Definitions":

i. Article 2 is amended to delete these terms and definitions:

(1) Heated slab;

(2) Infiltration;

(3) Opaque areas;

(4) Overall thermal transfer value (OTTV); and

(5) Shading coefficient.

3. Article 8 of the building subcode, entitled "Means of Egress":

i. Section 813.3, line 4, is amended to replace the phrase "Section 512.0" with "the Barrier-free Subcode";

ii. Subsection 813.4.1.2 item 5 is amended to replace the phrase "15-pounds (73N)" with "8-pounds (39N)"; and

iii. Subsection 816.3 is amended to replace the phrases "Section 512.0—otherwise" with "the Barrier-free Subcode".

4. Article 9 of the building subcode, entitled "Fireresistive Construction":

i. Subsection 929.2.5 is amended to replace the phrase "UL 910 listed in Appendix A" with "NFiPA-262-1985 (ANSI)".

5. Article 28 of the building subcode, entitled "Plumbing Systems":

i. Section 2804.0 is deleted.

6. Appendix A of the building subcode, entitled "Referenced Standards":

i. Delete the subheading "ASHRAE" and all titles under the subheading.

ii. Under the subheading "BOCA", delete these titles:

(1) BOCA National Property Maintenance Code;

(2) BOCA National Plumbing Code; and

(3) BOCA National Private Sewage Disposal Code.

iii. Under the subheading CABO, delete this title:

(1) Model Energy Code.]

5:23-3.15 Plumbing subcode

(a) Rules concerning subcode adopted are as follows:

1. Pursuant to authority of P.L. 1975, c.217, the Commissioner hereby adopts the Model Code of the National Association of Plumbing-Heating-Cooling Contractors, known as "The National Standard Plumbing Code/[1990] **1993**", including all subsequent revisions and amendments thereto, as the plumbing subcode for New Jersey.

i. Copies of this code may be obtained from the sponsor at: NAPHCC, P.O. Box 6808, Falls Church, VA 22046.

2. "The National Standard Plumbing Code/[1990] **1993**", including all subsequent revisions and amendments thereto, may be known and cited as "the plumbing subcode."

(b) The following pages, chapters, sections, or appendices of the plumbing subcode are amended as follows:

1. (No change.)

2. The section entitled "Administration," comprising sections ADM 1.1 through ADM 1.13, is deleted in its entirety.

[2.]**3.** Chapter 1 of the plumbing subcode, entitled "Definitions," is amended as follows:

i.-vi. (No change.)

[vii. The definition of the term "multiple dwelling" is amended to delete the term "two" and substitute in lieu thereof the word "three."]

[viii.]**vii.** The definition of and the term "nuisance" is deleted.

[3.]**4.** Chapter 2 of the plumbing subcode, entitled "General Regulations," is amended as follows:

i. (No change.)

ii. Section 2.4.3 is amended to delete the phrase "or is approved by the administrative authority as having a desirable and accepted function and [as] **is** of ultimate benefit to the proper and continuing function of the plumbing system."

iii.-vi. (No change.)

vii. Section 2.19.1 is amended to delete the **blank and the** words ["200 feet or" and "other" on line 5.] **"feet of any property line of the premises, or other."**

viii. Section 2.19.2 is amended to delete the words "the Health Department or other agency having jurisdiction" and substitute in lieu thereof "The New Jersey Department of Environmental Protection and Energy."

Recodify existing viii. as **ix.** (No change in text.)

[4.]**5.** Chapter 3 of the plumbing subcode, entitled "Materials," is amended as follows:

i.-iv. (No change.)

v. Section [3.5.1] **3.11.1** is amended to delete the phrase "approved by the Administrative authority".

vi. Section [3.5.2] **3.11.2** is amended to delete the phrase "except as may be otherwise authorized by the administrative authority".

vii. (No change.)

Recodify existing 5.-6. as **6.-7.** (No change in text.)

[7.]**8.** Chapter 6 of the plumbing subcode, entitled "Interceptors," is amended as follows:

i. (No change.)

ii. Section 6.3.2b is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the word "required" on line [5] **4.**

iii. Section 6.4.4 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the word "approval" on line [3] **2.**

[8.]**9.** Chapter 7 of the plumbing subcode, entitled "Plumbing Fixtures," is amended as follows:

i. Section 7.2.1 is amended to read "Water closets either flush tank, flushometer tank or flushometer valve operated shall be designed, manufactured and installed to be operable and adequately flushed with an average of 1.6 gallons or less of water per flushing cycle, when tested at any one test pressure in accordance with listed standards. Only pressurized (not gravity flow) water closets are acceptable for commercial uses. Commercial uses are A, E, B and M uses with an occupancy with more than two water closets connected to the building sewer."

(1) Exception: Installation of water closets bearing a manufacturer's date stamp indicating a date of manufacture prior to July 1, 1991 and requiring an amount in excess of 1.6 gallons per flush shall be permitted.

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ii. Section 7.2.2 is amended to insert the number "1" in the blank provided.

iii. Section 7.2.3.1 is amended to insert the number "2.2" in the blank provided.

iv. Section 7.2.3.2 is amended to insert the number ".25" in the blank provided.

v. Section 7.2.4 is amended to insert the number "2.2" in the blank provided.

vi. Section 7.2.5 is amended to insert the number "2.5" in the blank provided.

Recodify existing i.-iii. as **vii.-ix.** (No change in text.)

[iv.]**x.** [Table 7.24.1] Note #1 **to Tables 7.24.1A, 7.24.1B, 7.24.1C, 7.24.1D and 7.24.1E** is amended to delete the words "for handicap requirements see local, state, [and] **or** national [ordinances] **codes**" in **the second** [third] sentence.

Recodify existing v. as **xi.** (No change in text.)

[9.]**10.** Chapter 9 of the plumbing subcode, entitled "Indirect Waste Piping and Special Waste," is amended as follows:

i. (No change.)

ii. Section 9.3.2 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the words "administrative authority" on lines **3 and** 4.

iii. Section 9.7.2 is amended to delete the phrase "submitted to, and accepted by," on line [2] **7** and in lieu thereof, substitute the phrase "approved in accordance with [N.J.S.A.] **N.J.A.C.** 5:23-3.3."

[10.]**11.** Chapter 10 of the plumbing subcode, entitled "Water Supply and Distribution," is amended as follows:

i.-vi. (No change.)

vii. Section 10.8.1 is amended to add the phrase "as required by the authority having jurisdiction" after the word "practice" on line [5] **4.**

viii. (No change.)

Recodify existing 11.-12. as **12.-13.** (No change in text.)

[13.]**14.** Chapter 13 of the plumbing subcode, entitled "Storm Drains," is amended as follows:

i. Section 13.1.5**a** is amended to [delete the words on lines 1 and 2 "around the perimeter of all buildings having basements, cellars or crawl spaces or floors below grade" and in lieu thereof, substitute the words] **read "subsoil drains shall be provided** in accordance with [Section 1224.4.1 of] the building subcode".

ii. Section 13.9.1 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the word "authority" on line [6] **5.**

[14.]**15.** Chapter 14 of the plumbing subcode, entitled "Medical Care Facility Plumbing Equipment," is amended as follows:

[i. Section 14.21 is amended to delete the words "Administrative Authority" and in lieu thereof substitute "Authority having jurisdiction."

[ii.]**i.** Section 14.25.2 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the words "administrative authority" on line [5] **4.**

[15.]**16.** Chapter 16 of the plumbing subcode, entitled "Regulations governing individual sewage disposal systems for homes and other establishments where public sewage systems are not available" and comprising sections 16.1 through [16.15.9] **16.12.1.13,** is deleted in its entirety [with the exception of section 16.1.7 to remain as it is].

Note: Existing standards of the Department of Environmental Protection **and Energy** and boards of health with respect to individual on-site sewage disposal systems remain in effect.

[16.]**17.** Chapter 17 of the plumbing subcode, entitled "Potable water supply system [pumps]" and comprising sections 17.1 through 17.15.2 is deleted in its entirety.

Note: Existing standards of the Department of Environmental Protection **and Energy** and boards of health with respect to individual on-site water supply systems remain in effect.

Recodify existing 17. as **18.** (No change in text.)

[18. Appendix D, entitled "Water Conservation," is amended as follows:

i. Item D.2 is amended to read: water closets, either flush tank, flushometer tank or flushometer valve operated, shall be designed, manufactured and installed to be operable and adequately flushed with an average of 1.6 gallons or less of water per flushing cycle, when tested at any one test pressure in accordance with listed standards. Only pressurized (not gravity flow) water closets are acceptable for commercial uses. Commercial uses are A, E, B, and M uses with an occupancy requiring more than one fixture for persons of either sex.

(1) Exception: Installation of water closets bearing a manufacturer's date stamp indicating a date of manufacture prior to July 1, 1991 and requiring an amount in excess of 1.6 gallons per flush shall be permitted.

ii. Item D.4 is amended to insert the number 3 in the blank provided and to add a note after line 4 to read "Note: See Energy subcode for public lavatories flow rate value."

iii. Item D.5 is amended to insert the number 3 in the blank provided.

iv. Item D.6 is amended to insert the number 3 in the blank provided.

v. Item D.7 entitled "Water Conservation—Barrier Free Lavatory Faucets" is amended to delete the text and substitute in lieu thereof the words "See the State Barrier Free Subcode N.J.A.C. 5:23-7."]

19. (No change.)

[(c) The following amendments are made to the 1991 Supplement to the 1990 National Standard Plumbing Code.

1. Chapter 2 entitled "General Regulations" is amended as follows:

i. Section 2.16 is amended to insert the number "Forty-two" in the blank space under item (a) and to insert the number "Twenty-four" in the blank space under item (b). Under item (c), delete the words "Section 3.12.1" and substitute in lieu thereof the words "N.J.A.C. 5:23-2.9".

2. Chapter 5 entitled "Traps and Cleanouts" is amended as follows:

i. Section 5.3.2 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the words "administrative authority" on line 2.

3. Chapter 6 entitled "Interceptors" is amended as follows:

i. Section 6.3.2(b) is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the word "required" on line 5.

4. Chapter 9 entitled "Indirect Water Piping and Special Waste" is amended as follows:

i. Section 9.1.6 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the words "Administrative Authority" on line 4.

ii. Section 9.3.2 is amended to add the words "in accordance with N.J.A.C. 5:23-3.3" after the words "Administrative Authority" on line 4.

5. Chapter 11 entitled "Sanitary Drainage Systems" is amended as follows:

i. Section 11.7.6 is amended to add the phrase "in accordance with N.J.A.C. 5:23-3.3" after the words "Administrative Authority".

6. Chapter 13 entitled "Storm Drains" is amended as follows:

i. Section 13.1.1 is amended to add the words "in accordance with N.J.A.C. 5:23-3.3" after the words "Administrative Authority".

ii. Section 13.1.2 is amended to delete the words "Administrative Authority" and substitute in lieu thereof "Authority having jurisdiction".

iii. Section 13.1.5 is amended to delete the words on lines 1 and 2 "around the perimeter of all buildings having basements, cellars or crawl spaces or floors below grade" and in lieu thereof, substitute the words "in accordance with Section 1224.5 of the building subcode".

7. Chapter 16 entitled "Regulations Governing Individual Sewage Disposal Systems for Homes and Other Establishments Where Public Sewage Systems Are Not Available" is deleted.]

5:23-3.16 Electrical subcode

(a) Rules concerning **the** subcode adopted are as follows:

1. Pursuant to authority of P.L. 1975, c.217, the Commissioner hereby adopts the Model Code of the National Fire Protection Association known as "The National Electrical Code/[1990] **1993,**" including all subsequent revisions and amendments thereto, as the electrical subcode for New Jersey.

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i. (No change.)

2. The National Electrical Code/[1990] **1993**, including all subsequent revisions and amendments thereto, may be known and cited as "the electrical subcode."

(b) The following chapters or articles of the electrical subcode are amended as follows:

1. Article 90 of the electrical subcode, entitled "Introduction," is amended as follows:

i. Section 90-2(b)(5) is amended to delete the term "(FPN):" in the seventh line and add the words "the installation of utilization equipment and its associated wiring on private property (see section 90-2(a)(1) for installations covered) and" after the words "this Code cover" in the tenth line.

Recodify existing i. as **ii.** (No change in text.)

2. (No change.)

3. Chapter 3 of the electrical subcode, entitled "Wiring Methods and Materials," is amended as follows:

i. Section 300-4(a)(1) is amended to delete [all] **the** wording from "so that the edge . . ." on line [3] **three** through [". . . cover the area of the wiring," on line 8] **". . . cannot be maintained" on line five** and in lieu thereof substitute "as required by the building subcode[".] **where the distance between the edge of the hole to the nearest edge of the wood member is less than 1¼ inches (31.8 mm)."**

4. Chapter 5 of the electrical subcode, entitled "Special Occupancies," is amended as follows:

[i. In Article 550, entitled "Mobile Homes and Mobile Home Parks", delete from the title the words "Mobile Homes and".

(1) Section 550-1 is amended to delete the phrase "within or on mobile homes" on line 2.]

i. Exception to the section 500-3(a)(4), section 514-5(b) and section 514-5(c) are amended to delete the phrase "authority having jurisdiction" and substitute in lieu thereof the phrase "fire protection subcode officials."

[(2)]**ii.** Part B **of Article 550,** entitled "Mobile Homes," comprising sections 550-5 through 550-15 is deleted in its entirety with the exception of section 550-5 which shall be retained.

[(A)]**(1)** Exception—Part B is retained in its entirety in the case of mobile homes undergoing repair or alteration work.

Recodify existing ii. as **iii.** (No change in text.)

5:23-3.17 Fire protection subcode

(a) Rules concerning **the** subcode adopted are as follows:

1. Pursuant to authority of P.L. 1975, c.217, as amended, the Commissioner hereby adopts the following portions of the building, electrical and mechanical subcodes, to the extent delineated in N.J.A.C. 5:23-3.4, as the [Fire Protection Subcode] **fire protection subcode** for New Jersey.

i. BOCA National Building Code/[1990] **1993** of the Building Officials and Code Administrators International Inc. (N.J.A.C. 5:23-3.14):

[(1) Sections 513.0 and 514.0 of article 5—General Building Limitations;]

[(2)]**(1)** [Article 6] **Chapter 4**—Special Use and Occupancy [Requirements];

[(3) Article 8—Means of Egress] **(2) Chapter 7—Fireresistant Materials and Construction;**

[(4) Article 9—Fire Resistive Construction] **(3) Chapter 8—Interior Finishes;**

[(5) Article 10] **(4) Chapter 9**—Fire Protection Systems;

[(6) Section 2002.0 of Article 20—Plastic] **(5) Chapter 10—Means of Egress;**

[(7) Sections 2301.0 and 2302.0 of Article 23] **(6) Sections 1506.0 and 1511.0 of Chapter 15**—Roofs and Roof [Coverings] **Structures;**

[(8) Article 24—Masonry Fireplaces] **(7) Section 2114.0 of Chapter 21—Masonry;**

(8) Sections 2603.0 through 2605.0 of Chapter 26—Plastic;

(9) [Article 25—Mechanical Equipment and Systems] **Section 3106.0 of Chapter 31—Special Construction;**

(10) [Sections 2606.0 through 2611.0 of Article 26—Elevator, Dumbwaiter and Conveyor Equipment, Installation and Maintenance] **Section 3305.0 of Chapter 33—Site Work, Demolition and Construction;**

(11) [Sections 3018.0 and 3020.0 of Article 30—Precautions During Building Operations] **Section 3406.0 of Chapter 34—Existing Structures.**

ii. National Electrical Code/[1990] **1993** of the National Fire Protection Association (N.J.A.C. 5:23-3.16).

(1)-(4) (No change.)

iii. BOCA National Mechanical Code/[1990] **1993** of the Building Officials and Code Administrators International Inc. (N.J.A.C. 5:23-3.20):

[(1) Section 312.0 of Article 3—Air Distribution Systems;]

[(2)]**(1)** [Article] **Chapter** 4—Mechanical Equipment;

[(3) Article] **(2) Chapter** 5—Kitchen Exhaust Equipment;

[(4) Article] **(3) Chapter** 9—Flammable and Combustible Liquid Storage and Piping Systems;

[(5) Article] **(4) Chapter** 10—Combustion Air;[.]

(5) Chapter 12—Chimneys and Vents;

(6) Chapter 14—Fireplaces, Solid Fuel-Burning and Gas Accessory Appliances.

2. (No change.)

(b) (No change.)

5:23-3.18 Energy Subcode

(a) Rules concerning the [Energy Subcode] **subcode** adopted are as follows:

1. Pursuant to authority of P.L. 1975, c.217, as amended, the Commissioner hereby adopts the model code of the Building Officials and Code Administrators International, Inc., known as the BOCA National Energy Conservation Code/[1990] **1993**, including all subsequent revisions and amendments thereto, as well as the Illuminating Engineering Society's standard known as LEM-1, 1982, "IES Recommended Procedure for Lighting Power Limit Determination," including all subsequent revisions and amendments thereto**, as the energy subcode for New Jersey.**

i. Copies of the BOCA National Energy Conservation Code/[1990] **1993** may be obtained from the sponsor at BOCA, 4051 West Flossmoor Road, Country Club Hills, Illinois, 60477-5795.

ii. Copies of LEM-1, 1982, "IES Recommended Procedure for Lighting Power **Limit** Determination," may be obtained from the sponsor at IES, 345 East 47th Street, New York, New York 10017.

iii. (No change.)

2. Any reference to the building code, mechanical code, or plumbing code listed in [Appendix A] **Chapter 8** shall be considered a reference to the appropriate adopted building, mechanical, or plumbing subcode in N.J.A.C. 5:23-3.

(b) The following chapters [or articles] of the [Energy Subcode] **energy subcode** are amended as follows:

1. The following amendments are made to [Article] **Chapter** 1 of the [Energy Subcode] **energy subcode** entitled "Scope and Application":

i. Section [E-100.1] **E-101.1** is deleted in its entirety.

ii. [Section E-1002 is amended to delete Exception 4.] **Section E-101.3 is amended to delete the last sentence.**

2. [Article] **Chapter** 2 of the [Energy Subcode] **energy subcode**, entitled "Definitions," Section E-201—General Definitions, is amended to add the following definitions.

i.-xvii. (No change.)

[xviii. "Reheat Systems" means—Mechanical systems which cool all entering air down to the coolest temperature required for the building. The air is then reheated to the temperature necessary for other parts of the building.]

Recodify existing xix.-xxvii. as **xviii.-xxvi.** (No change in text.)

3. The following amendments are made to [Article] **Chapter** 3 of the [Energy Subcode] **energy subcode** entitled "Building Envelope":

i. [In] Section [E-301.1,] **E-302.1 is amended to delete the words "or the CABO Model Energy Code" and to** add the words "In all municipalities of the State of New Jersey, thermal transmittance values shall be determined using the figure of 5,500 annual Fahrenheit heating degree days".

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4. The following amendments are made to [Article] **Chapter** 4 of the [Energy Subcode] **energy subcode** entitled"[Warm Air] Heating, Ventilating and Air Conditioning Systems and Equipment":

i. [In Section E-401.1.1, delete "Except where established by local weather data, outdoor design temperature shall be selected for listed locations in the ASHRE Handbook, Fundamentals Volume, listed in Appendix A, from columns of 97 1/2 percent values for heating and 2 1/2 percent values for cooling. A list of selected locations may also be found in Appendix B."] **Delete section E-402.1.1** and substitute the words "Design temperatures shall be as follows: Winter 14°F.; Summer DB 90°F.; Summer WB 76°F.".

5. The following amendments are made to [Article] **Chapter** 5 of the [Energy Subcode] **energy subcode** entitled "Plumbing Systems":

[i. Delete Section E-502.1, "Water Closets and Urinals."

ii. Section E-502.4 is amended to add the words "other than dwelling units served by individual water heaters" after the words "Individual showers in all buildings"; to add the words "unless the water heater outlet temperature is limited to 110°F" after Appendix A"; and to delete the sentence: "Water temperature control valves shall be equipped with high limit stops and adjusted to a maximum hot water setting of 110°F (43°)."]

i. Delete section E-503.0.

6. The folloiwng amendment is made to [article] **Chapter** 6 of the [Energy Subcode] **energy subcode** entitled "Electrical Systems":

i. In Section [E-601.2] **E-602.2**, add the words "In buildings of Use Group R-2 which are under a condominium or cooperative form of ownership only, electrical energy use by the occupants of each dwelling unit may be determined by means of checkmetering rather than by use of a separate meter owned by the electric utility for each dwelling unit."

7. The following amendments are made to [article] **Chapter** 7 of the [Energy Subcode] **energy subcode** entitled "Alternative Systems":

i. Section [700.1] **E-701.1** is amended to delete the words "this code" on lines **3 and** 6 and, in lieu thereof, substitute "the energy subcode."

8. The following amendment is made to Chapter 8 of the energy subcode entitled "Referenced Standards";

i. Delete the subheading CABO and all titles listed below the subheading.

Recodify existing 8. as **9.** (No change in text.)

(c) (No change.)

5:23-3.20 Mechanical [Subcode] **subcode**

(a) Rules concerning **the** subcode adopted are as follows:

1. Pursuant to authority P.L. 1975, c.217, the Commissioner hereby adopts the model code of the Building Officials and Code Administrators International, Inc. known as the "BOCA National Mechanical Code/[1990] **1993**", including all subsequent revisions and amendments thereto. This code is hereby adopted by reference as the Mechanical Subcode for New Jersey subject to the modifications stated in (b) below.

i. Copies of this code may be obtained from the sponsor at: BOCA International, 4051 W. Flossmoor Road, Country Club Hills, Illinois 60478-5795.

ii. The "BOCA National Mechanical Code/[1990] **1993**," including all subsequent revisions and amendments thereto, may be known and cited as the "mechanical subcode."

2. Any references to the building code, plumbing code, or NFiPA 70 listed in [Appendix A] **Chapter 21** shall be considered a reference to the appropriate adopted building, plumbing, or electrical subcode in N.J.A.C. 5:23-3.

[3. The 1991 supplement to the BOCA National Mechanical Code/1990 is adopted by reference with modifications cited in (c) below as part of the mechanical subcode for New Jersey.]

(b) The following [articles] **chapters**, sections or pages of the BOCA National Mechanical Code/[1990] **1993** are amended as follows:

1. [Article] **Chapter** 1 of the mechanical subcode, entitled "Administration and Enforcement," is deleted in its entirety.

2. [Article] **Chapter** 2 of the mechanical subcode, entitled "Definitions," is amended as follows:

i. Section [M-200.3] **M-201.3** is amended to delete the words "codes listed in [Appendix A] **Chapter 21**" on line [2] **3**, and in lieu thereof, substitute "subcodes."

ii.-iii. (No change.)

iv. The definition of the term "building" is deleted and the definition found in N.J.A.C. 5:23-1.4 is substituted;

Recodify existing iv. as v. (No change in text.)

[v.]**vi. The definition of the term "code official" is deleted in its entirety, and [substitute in lieu thereof,] the following language is substituted**: "For the purpose of the mechanical subcode, the term "code official" shall mean the appropriate subcode **official** as designated in N.J.A.C. 5:23-[4] **3.4**."

[vi. The term and definition of "department" is deleted in its entirety.

vii. The term and definition of "department having jurisdiction" is deleted in its entirety.

viii. The definition of the term "hazardous location" is amended to delete the words "building code" in line 3, and in lieu thereof, substitute "building subcode."

ix. The term and definition of "nuisance" is deleted in its entirety.]

vii. The definition of the term "structure" is deleted and the definition found in N.J.A.C. 5:23-1.4 is substituted.

3. [Article] **Chapter** 4 of the mechanical subcode, entitled "Mechanical Equipment," is amended as follows:

i. Section [401.1] **M-403.1** is amended to delete "Section [M-108] **M-107.0**" on line 3, and, **to substitute** in lieu thereof, [substitute] "N.J.A.C. 5:23-3.7."

4. [Article] **Chapter** 5 of the mechanical subcode, entitled "Kitchen Exhaust Equipment," is amended as follows:

i. Section [M-508.0] **M-509.0**, "Test and Cleaning Schedule" is deleted.

5. [Article] **Chapter** 9 of the mechanical subcode, entitled "Flammable and Combustible Liquid Storage and Piping Systems," is amended as follows:

i. Section [M-900.1] **M-901.1** is amended to add the words "For those systems that are subject to the Department of Environmental Protection **and Energy's** Underground Storage Tank Systems rules, N.J.A.C. 7:14B, the requirements of this article that conflict with the DEPE rules shall be inapplicable."

6. [Article] **Chapter** 15 of the mechanical subcode, entitled "Incinerators and Crematories," is amended as follows:

i. Section [M-1500.2] **M-1501.2** is deleted in its entirety.

[7. Article 16 of the mechanical subcode, entitled "Ventilation Air" is amended as follows:

i. Section M-1602.0 is deleted in its entirety.

ii. Section M-1603.0 is deleted in its entirety.

iii. Section M-1604.1, is amended to delete the words "of Table M-1603.1" and "Section M-1603.0" and substitute in lieu thereof, "N.J.A.C. 5:23-3.20A" and "indoor air quality procedure specified in "N.J.A.C. 5:23-3.20A" respectively.]

[8.] **7.** [Article] **Chapter** 17 of the mechanical subcode, entitled "Air Quality" is deleted in its entirety.

[9.] **8.** [Article] **Chapter** 19 of the mechanical subcode, entitled "Energy Conservation" is deleted in its entirety.

[10.] **9.** [Article] **Chapter** 20 of the mechanical subcode, entitled "Boilers and Pressure Vessels, Maintenance and Inspection," is deleted in its entirety, with the exception of section [M-2000.2] **M-2001.2.**

[11.] **10.** The following amendments are made to [Appendix A] **Chapter 21** of the mechanical subcode, entitled "Referenced Standards":

i. Under the subheading "ASHRAE," delete the following title:

(1) Energy Conservation in New Building Design—**with Addendum 90A-a-1987.**

ii. Under the subheading "BOCA," delete the following titles:

(1) **BOCA** National Building Code.

(2) **BOCA** National Plumbing Code.

iii. Under the subheading "NFiPA" delete the following title:

(1) National Electrical Code.

[(c) The following section of the 1991 supplement to the Mechanical Subcode is modified as follows:

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1. Section M-1602.0 is deleted in its entirety.
2. Appendix A of the Mechanical Subcode:
i. Under the subheading "ASHRAE", delete these titles:
(1) Thermal Environmental Conditions for Human Occupancy;
(2) Energy Conservation in New Building Design—with Addendium 90A-a-1987; and
(3) Handbook of Fundamentals.
ii. Under the subheading "BOCA", delete these titles:
(1) BOCA National Building Code; and
(2) BOCA National Plumbing Code.
iii. Under the subheading "NFiPA", delete this title:
(1) National Electrical Code.]

5:23-3.20A [Indoor air quality subcode] **(Reserved)**

[(a) Pursuant to authority of P.L. 1975, c.217, as amended, the Commissioner hereby adopts the nationally-recognized standard of the American Society of Heating, Refrigerating and Air Conditioning Engineers, Inc., known as ASHRAE 62-1989 (Ventilation for Acceptable Indoor Air Quality), including all subsequent revisions and amendments thereto, as the standard for building ventilation and indoor air quality in all buildings or portions of buildings subject to this chapter in which mechanical ventilation is utilized. This standard is hereby adopted by reference as the indoor air quality subcode for New Jersey.

1. Copies of this standard may be obtained from the sponsor at: ASHRAE Publications Sales Department, 1791 Tullie Circle NE, Atlanta, GA 30329.]

5:23-3.21 One and two family dwelling subcode

(a) Rules concerning **the** subcode adopted are as follows:

1. Pursuant to authority of P.L. 1975, c.217, the Commissioner hereby adopts the model code of the Council of American Building Officials known as "The CABO One and Two Family Dwelling Code/[1989] **1992**", including all subsequent revisions and amendments thereto, as the one and two family dwelling subcode for New Jersey, subject to the modifications stated in (b) below.

i. (No change.)

(b) The following articles or sections of the one and two family dwelling subcode are modified as follows:

1. Chapter 1 entitled "Administrative" is amended as follows:

i. (No change.)

ii. Section R-103 is deleted and the following substituted in lieu thereof: "The provisions of this code apply only to the construction, alteration, repair or increase in size of detached one or two family dwellings of use group R-4 **(including single family townhouses),** of type 5B construction not more than 2 stories or 35 feet in height and 4,800 square feet in area per floor, and not located in areas prone to flooding. Dwellings to be erected in areas identified as prone to flooding by the most recent Flood Insurance Rate Map published by the Federal Emergency Management Agency shall be constructed in conformity with the building subcode, and the option to use the one and two-family dwelling subcode as an alternative to the building subcode shall not apply.

iii. Sections R-104 through [R-114] **R-117** are deleted.

iv. Section [R-115] R-**118** is amended to change the definitions as follows:

(1)-(4) (No change)

[(5) The definition of the term "Story (first)" is amended to add, after the word "grade," the phrase "except that a basement shall be considered as a story above grade when the finished surface of the floor above the basement is more than six feet above grade, more than six feet above the finished ground level for more than 50 percent of the total building perimeter, or more than 12 feet above the finished ground level at any point.]

2. Chapter 2 entitled "Building Planning" is amended as follows:

i. [Sec.] **Section** R-201.2 is amended to modify Table R-201.2 to read as follows:

Table No. R-201.2
CLIMATIC AND GEOGRAPHIC DESIGN CRITERIA

Roof Live Load (lbs./sq. ft.)	Roof Snow Load (lbs./sq. ft.)	Wind Pressure (lbs./sq. ft.)	Subject to Damage from Seismic Condition by Zone	Weathering	Frost Line Depth	Subject to Damage from Termite	Decay
20 See note 1	20 See notes 1, 4	[34] see **Appendix A and** notes 5, [24] [See note] 6, [18] [See note] 7.	See note 3	Severe See note 2	2'-6" (Southern Area) 3'-0" (Northern Area) See notes 2, 4	Yes	Yes

Notes:
1. Roof live and snow loads are not additive.
2. Weathering may require a higher strength concrete or grade of masonry than necessary to satisfy structural requirements of this code. The grade of masonry units shall be determined from ASTM C34, C55, C62, C73, C90, **C129,** C145, C216, or C652 listed in Section S-26.201. The frost line depth may require deeper footings than indicated in Figure R-303.
3. New Jersey is divided into two zones: Zone 1 consists of Monmouth and Burlington Counties and all counties to the south. Zone 2 consists of Mercer and Middlesex Counties and all counties to the North **(see N.J.A.C. 5:23-9.4).**
4. The enforcing agency having jurisdiction may establish values other than the ones listed for "roof snow load", and "frost line depth" if warranted by documented local climatic and geographic conditions.
5. Wind [pressure] **speed** for Atlantic, Cape May, Monmouth and Ocean counties, and Bass River, Washington, Woodland townships in Burlington County **shall be 90 mph.**
6. Wind [pressure] **speed** for Bergen, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Morris, Passaic, Salem, Somerset, Union, and Burlington (except for Bass River, Washington and Woodland townships) counties **shall be 80 mph.**
7. Wind [pressure] **speed** for Hunterdon, Warren and Sussex counties **shall be 70 mph.**

ii. (No change.)

iii. Section R-203.5 "Required heating" is deleted.

[iii.] **iv.** [Sec.] **Section** R-209.1—Opening Protection—Delete and substitute in lieu thereof the following: "Openings from a private garage directly into a room used for sleeping purposes shall not be permitted. Other openings between the garage and residence shall be equipped with solid core wood doors not less than 1¾ inches in thickness or approved equivalent. [A raised sill shall also be provided between garage and adjacent interior spaces with a minimum height of 4 inches";] **The sills of all door openings between garages and adjacent interior spaces shall be raised not less than 4 inches above the garage floor."**

Recodify existing iv. as **v.** (No change in text.)

[v.] **vi.** [Sec.] **Section** R-212 under the second exception in the second line, delete "8½ inches" and substitute in lieu thereof, "8

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inches"; [R.-214.1, in the third line delete "four or more risers"] and substitute in lieu thereof, "three or more risers";

[vi. Sec. R-215.1 is amended to delete the second paragraph;]

vii. Section R-214.1 "Handrails": Delete paragraph 2 and replace with the following text: "All stairway handrails shall have a circular cross section with an outside diameter of at least 1¼ inches and not greater than 2 inches, or approved rails of equivalent graspability;

viii. Section R-215.1 "Smoke detectors required": Delete this section and replace with the following text: "Single or multiple station smoke detectors shall be installed and maintained at the following locations:

(1) In the immediate vicinity of the bedrooms;

(2) In all bedrooms; and

(3) In each story within a dwelling unit including basements. All detectors shall be interconnected such that the activation of one alarm will activate all the alarms in the individual unit. When the installation is complete, each detector, and all interconnecting wiring for multiple station detectors, shall be subject to acceptable testing in accordance with section 919.6 of the building subcode. All detectors shall be approved and listed and shall be installed in accordance with section 919.1 of the building subcode.

EXCEPTION: In dwellings or dwelling units with split levels and without an intervening door between the adjacent levels, a smoke detector installed on the upper level shall suffice for the adjacent lower level, provided that the lower level is less than one full story below the upper level.

[vii.] **ix.** [Sec.] **Section** R-215.2 is amended to delete the words **from** "or in buildings" to **the** end of paragraph;

Recodify existing viii. as **x.** (No change in text.)

3. Chapter 3, **entitled "Foundations,"** is amended as follows:

i. (No change.)

ii. From Section R-304.1 Concrete and Masonry: delete the exception;

[ii.] **iii.** Add new section [R-310] **R-312** "Pile Foundations," reading as follows: "Where buildings are constructed under the scope of this subcode that utilize pile foundations, [Article 12] **Chapter 18** of the building subcode shall apply."

4. Chapter 4, **entitled "Wall Construction,"** is amended as follows:

i. (No change.)

[ii. Sec. R-404.2, in second paragraph, fourth line, delete "one third" and substitute in lieu thereof, "one half";

iii. Sec. R-404.2, in second paragraph, fifth line, delete "one-third the thickness" and substitute "one half the thickness".

iv. Sec. R-4-404.13 in the second line, change "3 inches" to "4 inches."]

ii. From Section R-404.3.1 Unreinforced Masonry: delete the second paragraph of the exception.

iii. From Section R-404.3.2 Reinforced Masonry: delete the exception.

5. Chapter 6, **entitled "Floors,"** is amended as follows:

i. (No change.)

6. Chapter 7, **entitled "Roof Ceiling Construction",** is amended as follows:

i. (No change.)

7. Chapter 8, **entitled, "Roof Coverings",** is amended as follows:

i. (No change.)

ii. In Section R-801.3 Roof Covering Materials: On line eight delete the phrase "in areas . . . 3 feet" and replace with the phrase: "when the edge of the roof is less than 6 feet from the property line";

iii. Add a new section R-810 "Reroofing," reading as follows: Where an existing roof is replaced or recovered under the scope of this subcode, the provisions of the building subcode, section 1512.0, as amended, shall apply.

8. Chapter 9, **entitled "Chimneys and Fireplaces",** is amended as follows:

i. (No change.)

ii. Section R-902 is amended to add the sentence "Factory built chimneys shall conform to U.L. 103 and be installed in accordance with their listing."

Recodify existing ii.-iii. as **iii.-iv.** (No change in text.)

[iv. Sec.] **v. Section** R-903.7, in the second and fourth lines, change "2 inches" to "4 inches" **and add the sentence "The minimum clearance to combustibles from the exterior surface of the smoke chamber shall be 2 inches";**

Recodify existing v.-vi. as **vi.-vii.** (No change in text.)

9. Part IV—Mechanical, is amended as follows:

[i. Section M-1001, delete the words "Section R-108" and in lieu thereof insert "UCC regulations N.J.A.C. 5:23-3.6 and 3.7".

ii. Sec. M-1104—At the beginning of the paragraph add "When more than one fuel oil burning appliance is installed, a shutoff valve shall be installed at the connection to each appliance."

iii. Sec. M-1112—At the end of the section, add "Solid fuel burning room heaters shall be tested and labeled in accordance with UL 1482";

iv. Sec. M-1905.2—Add the following new paragraph "No piping shall be installed in supply air ducts, clothes chutes, chimneys, vents or shafts";

v. Sec. M-1909.3—Delete second paragraph;

vi. Sec. M-1917.1—Add after the first sentence "All pumps shall be listed and labeled by an approved agency."]

i. Section M-1001: Delete the words "Section R-108" and in lieu thereof insert "N.J.A.C. 5:23-3.6 and 3.7";

ii. Section M-1002.2: At the end of the section, add "Solid fuel burning room heaters shall be tested and labeled in accordance with UL 1482";

iii. Section M-1008 "Existing Mechanical Systems" is deleted;

iv. Section M-1009 "Inspections" is deleted;

v. Section M-1304.3 is amended to delete the words "conform to the requirements of part V of this code" and substitute in lieu thereof "conform to the requirements of the plumbing subcode";

vi. Section 1304.4 is amended to delete the words "Section P-2402" and substitute in lieu thereof "the plumbing subcode";

vii. Section M-1905 is amended to delete the words "Section P-2408" and substitute in lieu thereof "the plumbing subcode";

10.-11. (No change.)

[(c) The 1990 and 1991 Amendments to "The CABO One and Two Family Dwelling Code/1989" are adopted with the following modifications:

1. The following amendments are made to chapter 1 entitled "Administration":

i. Section R-113 is deleted.

2. The following amendments are made to Chapter 2 Entitled "Building Planning."

i. Table No. R-201.2 Page 9. Revise Footnote 2 to read, "Weathering may require a higher strength concrete or grade of masonry than necessary to satisfy structural requirements of this code. The grade of masonry units shall be determined from ASTM C34, C55, C62, C73, C90, C129, C145, C216, or C652 listed in S-26.201. The frost line depth may require deeper footings than indicated in Figure No. R-303."

ii. Sec. R-209 Opening Protection: Delete and substitute in lieu thereof the following: "Openings from a private garage directly into a room used for sleeping purposes shall not be permitted. Other openings between the garage and residence shall be equipped with solid core wood doors not less than 1¾ inches in thickness or approved equivalent. The sills of all door openings between the garage and adjacent spaces shall be raised not less than 4 inches (102 mm) above the garage floor".

iii. R-214.1 Handrails: Delete paragraph 2 and replace with the following text: "All stairway handrails shall have a circular cross section with an outside diameter of at least 1¼ inches and not greater than 2 inches, or approved rails of equivalent graspability".

iv. R-215.1 Smoke detectors required: Delete this section and replace with the following text: "Single- or multiple-station smoke detectors shall be installed and maintained at the following locations:

(1) In the immediate vicinity of the bedrooms;

(2) In all bedrooms; and

(3) In each story including basements.

All detectors shall be interconnected such that the actuation of one alarm will actuate all the alarms in the individual unit. When

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the installation of detectors is complete, each detector, and all interconnecting wiring for multiple-station detectors, shall be subject to acceptance testing in accordance with section 1018.6 of the building subcode. All detectors shall be approved and listed and shall be installed in accordance with section 1018.1 of the building subcode.

Exception:

1. In dwellings or dwelling units with split levels and without an intervening door between the adjacent levels, a smoke detector installed on the upper level shall suffice for the adjacent lower level, provided that the lower level is less than one full story below the upper level."

v. Sections R-218.2, R-218.2.1, R-218.2.2, and R-218.2.3 are deleted in their entirety.

3. The following amendment is made to Chapter 3 entitled: Foundations:

i. From section R-304.1 Concrete and masonry: Delete the exception.

4. The following amendments are made to Chapter 4 entitled: Wall construction:

i. From section R-404.3.1 Unreinforced masonry: Delete the second paragraph of the exception.

ii. From section R-404.3.2 Reinforced masonry: Delete the exception.

5. The following amendment is made to Chapter 8 entitled: Roof Coverings:

i. In section R-801.3 Roof covering materials: On line eight, delete the phrase: "in areas . . . 3 feet" and replace with the phrase: "when the edge of the roof is less than 5 feet from the property line."

6. The following amendments are made to Chapter 9 entitled "Chimneys and Fireplaces":

i. Section R-902 is amended to add the sentence "Factory built chimneys shall conform to UL 103."

7. The following amendment is made to Chapter 11 entitled: Equipment, General:

i. Sec. M-1112: At the end of the section, add "Solid fuel burning room heaters shall be tested and labeled in accordance with UL 1482."

8. Part V—Plumbing, is amended as follows:

i. Chapters 20 through 24 are deleted in their entirety. All requirements for plumbing shall be provided in accordance with the plumbing subcode listed in N.J.A.C. 5:23-3.15.

9. The following amendment is made to Appendix A:

i. Wind Probability Map is deleted.

10. Appendix F is deleted in its entirety.]

5:23-4.3A Enforcing agency classification

(a)-(c) (No change.)

(d) Enforcing agencies shall be permitted to perform plan review activities in accordance with the agency classification for the use groups listed in the following schedule (keyed to section [301.0] **302.1** of the building subcode):

1. Class 3 agencies:

i.-iv. (No change.)

v. Use Group R-3 as permitted in the building subcode and including accessory private garages (section [608.0] **407.0**), radio and television antennae (section [622.0] **3108.0**) and swimming pools (section [623.0] **421.0**).

2. Class 2 agencies:

i.-x. (No change.)

xi. Use group H (paint spray booths, section [618.9] **419.2.1** only);

xii.-xx. (No change.)

3.-4. (No change.)

(e)-(f) (No change.)

5:23-4A.8 Approvals of building systems and compliance assurance programs

(a) Approved evaluation agencies shall be permitted to approve building systems and compliance assurance programs for the following types of industrialized/modular buildings and building components, including, without limitation, the factory built portions of the buildings of the Use groups listed in the Class 3 agency schedule set forth at N.J.A.C. 5:23-[3.10(c)1:] **4.3A(d)1.**

1.-10. (No change.)

(b)-(d) (No change.)

5:23-4A.11 Enforcing agency procedures and inspections

(a) Enforcing agencies shall issue construction permits for certified industrialized/modular buildings prior to installation, and shall not withhold issuance of construction permits for buildings containing certified building components that in all other respects comply with all applicable construction codes, provided that any industrialized/modular building or building component that the Department finds does not comply with this chapter shall be brought into compliance before installation. An application to an enforcing agency for a construction permit shall, when requested, in addition to any other requirements, contain:

1.-2. (No change.)

3. Detailed plans prepared by an architect or engineer licensed pursuant to law in the State of New Jersey for any site-built construction related to the installation of the industrialized/modular buildings or building components. All elements of the certified industrialized/modular buildings or building components that are not described or included in the approved building system documentation shall be subject to review, inspection and approval by the local enforcement agency. The plans for all on-site construction required in connection with the proper setup and erection of the certified industrialized/modular buildings or building component shall include, without limitation, foundation system, basement or crawl space, external utility systems, hook-ups and connections of various modules (boxes) and/or components. The review and approval of such plans shall be completed by:

i. (No change.)

ii. The local enforcement agency for the types of industrialized/modular buildings and building components listed in N.J.A.C. 5:23-4A.8(a) provided the agency is classified in accordance with N.J.A.C. 5:23-[3.10] **4.3A** and its classification meets the level of the specific project; and

4. (No change.)

(b)-(h) (No change.)

5:23-12.2 Referenced standards

(a) Periodic, routine and acceptance tests and inspections, if applicable, shall be required on all new and existing power elevators, escalators, dumbwaiters, moving walks, wheelchair lifts, manlifts and stairway chairlifts in accordance with the most recent edition of ASME A17.1 referenced in the building subcode. This subsection shall not apply to elevators in structures in Use Groups R-3 or R-4, **or to any elevator located wholly within a dwelling unit in an R-2 structure that is not accessible to the general public.**

(b)-(f) (No change.)

HEALTH

(a)

PUBLIC HEALTH COUNCIL

Operation of Clinical Laboratories

Proposed Readoption: N.J.A.C. 8:44

Authorized By: Public Health Council, William Frascella, Jr., O.D., Chairman.

Authority: N.J.S.A. 26:1A-7 and 45:9-42.34.

Proposal Number: PRN 1993-492.

A **public hearing** concerning this proposal will be held at 2:00 P.M. on Monday, September 13, 1993 at the following address:

Department of Health
Room 106 (Auditorium)
Health-Agriculture Bldg.
Trenton, New Jersey 08625-0360

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Submit written comments by October 7, 1993 to:
Samuel Thompson, Ph.D.
Director, Clinical Laboratory Improvement Service
New Jersey Department of Health
CN-361
Trenton, New Jersey 08625-0361
(609) 530-6150

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 8:44 (Chapter IV, State Sanitary Code) expires on November 2, 1993. On September 18, 1978, the Public Health Council adopted rules pertaining to the operation of clinical laboratories, pursuant to its authority under N.J.S.A. 26:1A-7. The rules were subsequently readopted by the Council on November 7, 1983 and again on November 7, 1988.

The chapter has been amended since the last readoption. By an amendment effective October 15, 1990, a Limited Purpose Laboratory (LPL) was created as a separate clinical laboratory licensing category. (See R.1990 d.512 at 22 N.J.R. 1323(a) and 3232(a).) That amendment was subsequently repealed, effective May 17, 1993 and, simultaneously, a new amendment was adopted. N.J.A.C. 8:44-2.2(b) was adopted to exempt from regulation clinical laboratories possessing a Federal Certificate of Waiver as defined by the Federal Clinical Laboratory Amendments of 1988 (CLIA '88) (PL 100-578) and regulations adopted thereunder (42 CFR Part 493, published in the Federal Register, February 28, 1992). (See R.1993 d.200 at 25 N.J.R. 1969(b).) In addition, an amendment relating to the performance of HIV testing has been proposed and that proposal is currently under consideration. (See 25 N.J.R. 2184(a).)

The Public Health Council has reviewed this chapter and determined it to be necessary, reasonable and proper for the purpose for which it was originally promulgated and is proposing this readoption without change. A complete review of the chapter is currently underway, and in the near future comprehensive changes will be proposed which reflect the most current accepted practices regarding clinical laboratory operation. However, in order to avoid expiration, pursuant to Executive Order No. 66(1978), the readoption of the rules without change is now being proposed. The rules will be effective for 18 months following the effective date of readoption, in light of the fact that a comprehensive set of revisions to the rule will be proposed shortly after readoption.

Since the rules provide physicians and other care-givers with information used in the diagnosis, prevention and treatment of disease, reliable clinical laboratory test results are crucial to patient health and safety. The reliability of the test results is dependent upon the proper operation of the laboratory facility and, therefore, it is essential to retain in effect rules which require proper patient specimen collection, identification and processing, accurate analyses and correct reporting of test values.

The rules being proposed for readoption are summarized below:

N.J.A.C. 8:44-2.1 provides definitions for the terms used in the chapter.

N.J.A.C. 8:44-2.2 describes the applicability of the rules and notes that the rules do not apply to (1) performance of anatomic pathology, (2) research and teaching laboratories, (3) laboratories operated by the Federal government, (4) blood banks licensed pursuant to N.J.S.A. 26:2A et seq. and (5) clinical laboratories possessing a Federal Certificate of Waiver as defined by CLIA '88.

N.J.A.C. 8:44-2.3 describes the duties and minimum qualifications of a laboratory director who shall be responsible for directing the laboratory's operation.

N.J.A.C. 8:44-2.4 describes the supervisory personnel necessary for a laboratory to operate, and describes the responsibilities and qualifications of both the general supervisor and technical supervisor.

N.J.A.C. 8:44-2.5 requires a laboratory to perform only those tests for which it is licensed, to successfully participate in a proficiency testing program designed to ensure that the laboratory is performing testing in a competent fashion, and to perform only tests within those specialties for which the laboratory director or supervisor has the appropriate qualifications. The rule further describes the qualifications the director or supervisor shall have if the laboratory is to perform tests in a given specialty.

N.J.A.C. 8:44-2.6 describes the technical personnel the laboratory shall have, including the qualifications of such personnel.

N.J.A.C. 8:44-2.7 requires the retention of the original analytical work records, the documentation of test procedures, the provision of adequate space and facilities, the receipt of appropriate test requests, the maintenance of records that document the disposition of patient specimens, and the proper reporting of test results.

N.J.A.C. 8:44-2.8 requires the surveillance of results, the correction of problems, the use of reliable methodologies and in-date testing materials, the proper collection, identification and processing of patient specimens and the performance of quality control procedures.

N.J.A.C. 8:44-2.9 and 2.10 provide that the Public Health Council on advice of the Commissioner of Health may amend, delete or promulgate any rules, so long as the rule is no less stringent than applicable Federal regulations.

N.J.A.C. 8:44-2.11 describes the reporting requirements imposed upon laboratory supervisors.

N.J.A.C. 8:44-2.12 and 2.13 describe the limitations on laboratories which handle live microorganisms or viruses pathogenic to humans, animals or birds.

Social Impact

Once readopted, the chapter will ensure that clinical laboratories operate in a fashion which will not endanger the public's health, by assuring that tests are adequately performed and reported. Failure to readopt the rules could seriously jeopardize the public health and well being.

Since their original adoption in 1978, the rules have been invaluable to the Department in its efforts to eliminate dangerous clinical laboratories. Once readopted, the chapter will make it possible for the Department to continue to pursue its goal of ensuring authentic and reliable test results are reported by clinical laboratories.

Economic Impact

Licensure and proficiency testing fees which are required by statute and other regulations (N.J.S.A. 45:9-42.30 and N.J.A.C. 8:45-1.3) comprise the major portion of the regulatory costs borne by New Jersey's laboratories. The costs of compliance with the rules proposed for readoption are small, since most, if not all, of those costs are already incurred in the provision of reliable laboratory services (the records required by the rules, for example, accession records, analytical records and copies of test reports, are records which are already an indispensible part of any laboratory operation and the various quality control procedures required by the rules are no more than is necessary to monitor the accuracy of the reported patient results). Also, since this chapter is being proposed for readoption without change, no new financial burdens are imposed upon the regulated industry.

Regulatory Flexibility Analysis

More than two-thirds of the licensed laboratories in New Jersey are operated by non-profit enterprises. There are approximately 110 private for-profit laboratories. About 95 percent of these facilities have fewer than 100 employees and they would, therefore, be classified as small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Annual licensure and proficiency testing fees are related to the size of the laboratory and, therefore, the small businesses pay considerably smaller fees. The requirements imposed are discussed in the Summary above; it is not anticipated that outside professional services are needed for compliance. Any waiver or relaxation of the rules proposed for readoption would have a negative impact on patient care not only because these small businesses represent a significant portion of all of New Jersey's laboratories but also because the Department has found that the most dangerous violations occur in precisely these types of facilities. Thus, the safety of those patients whose specimens happen to be tested at smaller laboratories would be seriously compromised unless the rules are uniformly applied to all laboratories regardless of their size.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:44.

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(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Proposed Amendments: N.J.A.C. 8:71

Authorized By: Drug Utilization Review Council,
Henry T. Kozek, Secretary.
Authority: N.J.S.A. 24:6E-6(b).
Proposal Number: PRN 1993-493.

A **public hearing** concerning these proposed amendments will be held on Monday, September 27, 1993, at 2:00 P.M. at the following address:

Room 804, Eighth Floor
Department of Health
Health-Agriculture Bldg.
Trenton, New Jersey 08625-0360

Submit written comments by October 7, 1993 to:

Mark A. Strollo, R.Ph., M.S.
Drug Utilization Review Council
New Jersey Department of Health
Room 501, CN 360
Trenton, New Jersey 08625-0360
609-292-4029

The agency proposal follows:

Summary

The List of Interchangeable Drug Products is a generic formulary, or list of acceptable generic drugs which pharmacists must use in place of brand-name prescription medicines, passing on the resultant savings to consumers.

For example, the proposed clindamycin phosphate 1% topical solution could be used as a less expensive substitute for Cleocin T, a branded prescription medicine. Similarly, the proposed metoprolol tartrate 50 mg and 100 mg tablets, could be substituted for the more costly branded product, Lopressor.

The Drug Utilization Review Council is mandated by law to ascertain whether these proposed medications can be expected to perform as well as the branded products for which they are to be substituted. Without such assurance of "therapeutic equivalency," any savings would accrue at a risk to the consumer's health. After receiving full information on these proposed generic products, including negative comments from the manufacturers of the branded products, the advice of the Council's own technical experts, and data from the generics' manufacturers, the Council will decide whether any of these proposed generics will work just as well as their branded counterparts.

Every proposed manufacturer must attest that they meet all Federal and State standards, as well as having been inspected and found to be in compliance with the U.S. Food and Drug Administration's regulations.

Social Impact

The social impact of the proposed amendments would primarily affect pharmacists, who would need to either place in stock, or be prepared to order, those products ultimately found acceptable.

Many of the proposed items are simply additional manufacturers for products already listed in the List of Interchangeable Drug Products. These proposed additions would expand the pharmacist's supply options.

Physicians and patients are not adversely affected by this proposal because the statute (N.J.S.A. 24:6E-6 et seq.) allows either the prescriber or the patient to disallow substitution, thus refusing the generic substitute and paying full price for the branded product.

Economic Impact

The proposed amendments will expand the opportunity for consumers to save money on prescriptions by accepting generic substitutes in place of branded prescriptions. The full extent of the saving to consumers cannot be estimated because pharmacies vary in their prices for both brands and generics.

Some of the economies occasioned by these amendments accrue to the State through the Medicaid, Pharmaceutical Assistance to the Aged and Disabled Program, and prescription plan for employees. A 1988 estimate of average savings per substituted Medicaid prescription was $7.31. However, the number of prescriptions that will be newly substituted due to these proposed amendments cannot be accurately assessed in order to arrive at a total savings.

Regulatory Flexibility Analysis

The proposed amendments impact many small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., specifically, over 1,500 pharmacies and several small generic drug manufacturers which employ fewer than 100 employees.

However, there are no reporting or recordkeeping requirements for pharmacies, and small generic drug manufacturers have minimal initial reports, and no additional ongoing reporting or recordkeeping requirements. Further, these minimal requirements are offset by the increased economic benefits accruing to these same small generic businesses due to these proposed amendments.

Full text of the proposed amendments follows:

Albuterol sulfate inh. soln. 0.083%	Copley
Alprazolam tabs 0.25mg, 0.5mg, 1mg	Alphapharm
Alprazolam tabs 0.25mg, 0.5mg, 1mg	Roxane
Amiloride/HCTZ tabs 5/50	West Point
Amiloride/HCTZ tabs 5/50	Danbury
Atenolol tabs 50mg, 100mg	Lemmon
Berocca Plus tabs substitute	Lini
Chlorothiazide tabs 250mg, 500mg	West Point
Clindamycin phosphate topical soln 1%	Paddock
Dexamethasone tabs 0.5mg, 0.75mg, 1.5mg, 4mg	Roxane
Digoxin Tabs 0.125mg, 0.25mg, 0.5mg	ALRA
Dyphylline/Guaifenesin elixir	Silarx
Endal HD liquid substitute	Great Southern
Entex capsule substitute	H.N. Norton
Entex liquid substitute	Silarx
Erythromycin/sulfisoxazole 200/600 susp	Barr
Fluocinonide cream 0.05%	Hamilton
Fluocinonide emollient 0.05%	Hamilton
Fluocinonide ointment 0.05%	Hamilton
Fluocinonide soln. 0.05%	Hamilton
Fluocinonide top soln 0.05%	Copley
Gemfibrozil tabs 600mg	Purepac
Hydrochlorothiazide tabs 25mg, 50mg	West Point
Hyoscamine sulfate sl tabs 0.125mg	Pegasus
Hyoscamine sulfate soln 0.125mg/ml	Pegasus
Hyoscamine sulfate tabs 0.125mg	Ferndale
Isosorbide dinitrate tabs 30mg	Par
Isoxsuprine HCl tabs 10mg, 20mg	Manuf. Chemists
Lactulose soln 10g/15ml	Copley
Lactulose soln 10g/15ml	Technilab
Leucovorin calcium tabs 5mg, 10mg, 15mg, 25mg	Roxane
Levothyroxine sodium tabs 88mcg, 112mcg	Daniels
Methazolamide tabs 25mg, 50mg	Copley
Methyldopa tabs 125mg, 250mg, 500mg	West Point
Methyldopa/HCTZ tabs 250/15, 250/25	West Point
Metoclopramide soln 5mg/5ml	Silarx
Metoprolol tartrate tabs 50mg, 100mg	Lemmon
Nadalolol tabs 20mg, 40mg, 80mg, 120mg	Bristol-Myers
Naproxen sodium tabs 275mg, 550mg	Hamilton
Naproxen sodium tabs 275mg, 550mg	Copley
Naproxen sodium tabs 275mg, 550mg	Danbury
Naproxen tabs 250mg, 375mg, 500mg	Hamilton
Naproxen tabs 250mg, 375mg, 500mg	Danbury
Nortriptyline HCl caps 10mg, 25mg, 50mg, 75mg	Creighton
Nystatin/triamcinolone oint.	Taro
Phenazopyridine tabs 95mg, 100mg, 200mg	Manuf. Chemists
Piroxicam caps 10mg, 20mg	Roxane
Robitussin AC expectorant substitute	Bio-Pharm
Robitussin DAC expectorant substitute	Bio-Pharm
Rondec DM drops substitute	Bio-Pharm
Rondec DM drops substitute	Silarx
Rondec-DM syrup substitute	Bio-Pharm
Rondec-DM syrup substitute	Silarx
Stuartnatal 1+1 tabs substitute	Eon
Sulfacetamide/prednisolone ophth soln.	Steris
Sulfasalazine tabs 500mg	Danbury
Tamoxifen citrate tabs 10mg	Zeneca
Timolol maleate tabs 5mg, 10mg	West Point
Triamterene/HCTZ tabs 37.5/25	Danbury
Trimethobenzamide HCl sup. 100mg, 200mg	Clay-Park
Urised Tabs subtitute	Manuf. Chemists

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HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Vision Care Services

Proposed Readoption with Amendments: N.J.A.C. 10:62

Proposed Repeal: N.J.A.C. 10:62-4

Proposed Repeal and New Rules: N.J.A.C 10:62-3 and 10:62-3 Appendix

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-6a(5)b(6)(7); 7a, b and c; 30:4D-12; and 42 CFR 440.50 and 440.120.

Proposal Number: PRN 1993-482.

Submit comments by October 7, 1993 to:

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The agency proposal follows:

Summary

The Division of Medical Assistance and Health Services (the Division) is readopting the existing rule known as the Vision Care Services Manual. The Division is readopting the existing text of N.J.A.C. 10:62-1 and 2, with amendments. The Division is repealing N.J.A.C. 10:62-3, entitled "Billing Procedures", because these procedures are not applicable to the current Fiscal Agent, Paramax/Unisys. The Division is recodifying N.J.A.C. 10:62-4 as N.J.A.C. 10:62-3, and will, with this readoption, describe the Health Care Financing Administration Common Procedure Coding System (HCPCS) in greater detail. In addition, the Division is adding the Fiscal Agent Billing Supplement as an Appendix.

The Vision Care Services chapter describes Medicaid policies and procedures for qualified providers, including ophthalmologists, optometrists, opticians and ocularists, who furnish essential eye care to Medicaid-eligible recipients. Eye care consists of examination and determination of the need for improvement of vision whenever possible, including the prescribing and issuing of corrective devices and/or vision training as appropriate.

The current text of this chapter is scheduled to expire on December 19, 1993, pursuant to Executive Order No. 66(1978), commonly known as the "sunset provision". The Division of Medical Assistance and Health Services (the Division) has reviewed the existing rule and found it generally to be necessary, adequate, reasonable, efficient and responsive for the purpose for which it was promulgated. The rule establishes those vision care services that are available to Medicaid recipients, and describes the procedures providers are required to follow when rendering services to Medicaid recipients.

The summary will explain more fully the contents of the respective subchapters and the Appendix. There will be a general synopsis of each subchapter, followed by a discussion of the changes in Medicaid policy associated with this proposal.

N.J.A.C. 10:62-1

Subchapter One describes the scope of professional services, definitions, and providers of professional services. It does not include optical appliances, which are discussed in Subchapter Two. Subchapter one also lists covered services, which include comprehensive eye exams, low vision work-ups, and the vision training program. For some of the services, prior authorization will continue to be required, as discussed in more detail below. The subchapter also describes prescription policies, recordkeeping policies, and basis for reimbursement. The policies contained in this subchapter and amendments associated with this readoption are explained below.

N.J.A.C. 10:62-1.1

There is a minor modification in the text indicating that the intent of this chapter is to correct and/or care for vision defects and/or treat eye diseases to maintain or improve the health of New Jersey Medicaid recipients. The term "recipient" is consistent with statutory terminology (see N.J.S.A. 30:4D-3i).

N.J.A.C. 10:62-1.2

The term "practitioner" is being used in place of "physician" to designate a licensed ophthalmologist or optometrist acting within the scope of licensure. The definition of "ophthalmologist' is being amended to specify that an ophthalmologist is a licensed medical doctor who is a diplomate in the American Board of Ophthalmology.

N.J.A.C. 10:62-1.3

The providers of professional service (practitioners) remain the same. These providers must be licensed ophthalmologists or optometrists in the State of New Jersey or the state in which he or she is located. These practitioners can be in private practice or associated with an independent clinic or an approved hospital. The term "clinic" is replacing "outpatient health care facility," since "clinic" is more accurate and consistent with Medicaid provider terminology.

Amendatory language is being added to N.J.A.C. 10:62-1.3(a) to indicate that all providers of eye care must follow the Medicaid enrollment procedures described in N.J.A.C. 10:49-3.2.

N.J.A.C. 10:62-1.4

The text of this section discusses professional services relating to vision, including office visits for evaluation and management and low vision work-ups. The term "covered services" also includes specific procedures listed at N.J.A.C. 10:62-3.2.

N.J.A.C. 10:62-1.5

This section discusses the comprehensive eye examination, listing the required elements of the comprehensive examination. The text presently in this section has not been changed.

N.J.A.C. 10:62-1.6, 7

These sections now contain provisions for the low vision examination and the low vision work-up which were found at N.J.A.C. 10:62-1.7 and 1.8. These sections regarding low vision examination and work-up are the same as the existing text. The text has been renumbered because of the deletion of the material discussing the routine office visit which was previously located at N.J.A.C. 10:62-1.6. In the readoption, we are amending references to direct the reader to the new text.

The text previously located at N.J.A.C. 10:62-1.6 described documentation required for a routine office visit or follow-up office visit. Because all practitioners are required to meet the recordkeeping policies set forth currently in N.J.A.C. 10:62-1.12, which is being recodified as N.J.A.C. 10:62-1.11 with the proposed readoption, this text is no longer necessary and is being deleted.

N.J.A.C. 10:62-1.8

There are some changes to the current text, previously codified at N.J.A.C. 10:62-1.9, to reflect procedural changes to the prior authorization process. The Division still requires prior authorization for the vision training program. The Division is adding a requirement for prior authorization for any extension of vision training, which will be based on a case-by-case review. There is an amendment indicating that the practitioner shall submit a written request on form FD-358 to the vision care unit. The request for vision training shall include preliminary findings, detailed reason(s) why further evaluation is needed, and any history of previous training. Upon receiving approval, the practitioner shall submit the work-up report to the vision care unit within 30 days of authorization. It is important for the practitioner to realize that the notice of acceptance or denial will come from the Fiscal Agent. The practitioner is also responsible for a detailed progress report upon completion of the training. This text was previously codified at N.J.A.C. 10:62-1.9.

N.J.A.C. 10:62-1.9

This section concerning prior authorization, previously codified at N.J.A.C. 10:62-1.10, has been amended to reflect procedural changes instituted with the Division's transition to Paramax/Unisys as the Division's Fiscal Agent. Practitioners must use form FD-358, Request for Prior Authorization for Vision Care Services. Prior authorization is required for a low vision work-up. A low vision work-up is more detailed than a low vision examination and requires a written report. The purpose of a low vision work-up is to determine what optical aids and/or devices can be prescribed to enable an individual to increase his/her range of

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vision. Vision training, which also requires prior authorization, is designed to increase vision capacity in recipients with poor and/or inconsistent or distorted vision localization.

The procedures for obtaining prior authorization are described both in N.J.A.C. 10:62-1.8(c) for low vision training and N.J.A.C. 10:62-1.9 for all services requiring prior authorization.

For Medicaid enrollees of the Garden State Health Plan or of a private HMO, HMO authorization of vision care services is also required.

N.J.A.C. 10:62-1.10

This section has been amended to clarify the Division's policy regarding the recipient's right to have a copy of his or her prescription. The prescription given to the recipient shall contain certain identifying information, such as the recipient's name, address, Medicaid case number, date of examination and diagnosis codes. If the recipient requests a duplicate prescription, the practitioner shall clearly indicate that the prescription is a duplicate. The text of this section was previously found at N.J.A.C. 10:62-1.11.

N.J.A.C. 10:62-1.11

The recordkeeping policies are not being changed with this readoption. Previously, this text was found at N.J.A.C. 10:62-1.12.

N.J.A.C. 10:62-1.12

As the result of Paramax/Unisys now being the Division's Fiscal Agent, N.J.A.C. 10:62-1.12, previously codified at N.J.A.C. 10:62-1.13, is being amended at (a) to indicate that the instructions for billing the Fiscal Agent are now contained in the Fiscal Agent Billing Supplement, which is an appendix to this chapter, and to delete duplicative listing of services from (d)1-4 and old (d) and (e). The appendix will be referenced, but not reproduced, in the New Jersey Administrative Code.

The new language contained in N.J.A.C. 10:62-1.12(b) instructs providers that vision care services must be identified by the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). A reference is provided indicating that the codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3. This aspect of provider billing will be explained in more detail in the summary for Subchapter Three.

The text of the existing code N.J.A.C. 10:62-1.13(a), 10:62-1.13(b) and 10:62-1.13(c) has been recodified to N.J.A.C. 10:62-1.12(c), N.J.A.C. 10:62-1.12(d) and N.J.A.C. 10:62-1.12(e), respectively. The section outlines certain limitations imposed by the Medicaid program. Medicaid recipients may not be charged for a broken appointment. When more than one member of a partnership or corporation examines or treats a recipient on the same day, only one service will be reimbursed by the Division. Services must be personally performed by the practitioner submitting the claim.

N.J.A.C. 10:62-2

The subchapter describes the optical appliances and services that are available. Covered services include optical lenses and frames, repairs, artificial eyes, low vision devices, and vision training devices. Certain optical appliances require prior authorization as indicated in N.J.A.C. 10:62-2.5. This will be discussed in more detail below.

N.J.A.C. 10:62-2.1

The scope is not being changed with this readoption.

N.J.A.C. 10:62-2.2

The definition of "providers of optical appliances" has been deleted because the limitation regarding New Jersey licensure no longer applies. The definition of an optician has been revised to indicate that the individual must be licensed by the State of New Jersey or the state in which the provider is located. In the definition of "optical appliances" the reference to "eligible provider" has been deleted because this is now covered by N.J.A.C. 10:62-2.3. The definition of "ocularist" remains the same.

N.J.A.C. 10:62-2.3

This section regarding qualified providers has been amended to indicate that all providers must follow the enrollment process requirements contained in N.J.A.C. 10:49-3.2. With respect to certain out-of-state providers, specifically ophthalmologists, optometrists or opticians, they must be duly licensed in their own state and must enroll in the New Jersey Medicaid program as indicated previously. Also, since ocularists are providers of service, the reference has been moved from subsection (b) to paragraph (a)4.

N.J.A.C. 10:62-2.4

The list of covered services remains the same. N.J.A.C. 10:62-2.4, "Covered Services", includes any limitations imposed on these services. However, there are some amendments associated with this readoption. According to N.J.A.C. requirements, repairs of optical appliances must be prior authorized when the charge to the New Jersey Medicaid Program is $15.00 or over. The old amount was $5.00. When the new fiscal agent assumed responsibility, the dollar figure was changed to require prior authorization only for repairs over $15.00, in order to simplify the paperwork and to provide service to the recipient as soon as possible.

When optical appliances, such as glasses, need to be replaced, three criteria come into play: the age of the person, the degree to which the person's vision may have changed since the appliance was dispensed, and possible loss of the appliance due to fire or theft.

Optical lenses ordinarily will not be replaced more frequently than once every two years for persons between the ages of 19 through 59, or more frequently than once a year for persons below the age of 19 years or 60 years of age and older. The age limits are not being changed. In addition, a specified magnitude of change in the prescription is necessary (at least 0.50 diopter in spherical and/or cylindrical power or change in axis of five degrees or more). More frequent replacement of the optical lenses requires prior authorization. (Reference is made to N.J.A.C. 10:62-2.4(a)7 below).

However, a new provision with this readoption is that if the patient's visual acuity has changed by 0.75 diopter, the replacement lenses do not require prior authorization.

Artificial eyes can now be replaced every three years, without prior authorization; however, more frequent replacement will still require prior authorization. Low vision devices are a covered service. Prior authorization is required if the charge to the Medicaid program is $150.00 or more, as shown at paragraph (a)5.

Prior authorization is not required when the recipient needs glasses or another optical appliance replaced beyond the time frames specified above. Ophthalmologists and optometrists may prescribe the new appliance if the recipient's vision has sufficiently changed.

When optical appliances are destroyed in a fire or stolen, providers must enter a written statement in the remarks section of the claim form (Item 19 of form MC-9) and retain a copy of the police or fire report in the provider's recipient file. The current policy requires the provider to obtain prior authorization (reference is made to N.J.A.C. 10:62-2.5(d)6iii). The new policy allows the provider to render the service without prior authorization, bill Medicaid directly, and maintain supporting documentation in his/her file.

There are situations where the prescriber may prescribe two pairs of glasses instead of bifocals or trifocals. The current rule is that the provider must obtain prior authorization. The proposed new rule allows the provider to prescribe a dual pair of glasses if the patient is physically handicapped or has a medication-related impairment. The provider shall attach a statement to the claim form.

For services rendered to Medicaid members of an HMO, HMO policies and procedures concerning prior authorization of services still apply.

N.J.A.C. 10:62-2.5

This section on prior authorization describes the procedure for requesting prior authorization. Providers must submit the form MC-9(A) to the Division's vision care unit. The provider will be notified of the Division's determination via a letter issued by the Division's fiscal agent. This procedure is generally applicable to all items and/or services that require prior authorization. If the recipient becomes ineligible after the appliance is ordered, but before delivery, the provider must now use the order date as the date of service. (See additional text at (c).)

If an item requires prior authorization, to insure reimbursement, the provider must not dispense the item until he or she has received approval from Medicaid. (Reference is made to N.J.A.C. 10:49-6.)

The requirement at (g)2 has been deleted, since it is already required at paragraph (g)1.

This section also indicates that prior authorization is required for: low vision devices when the total charge to the Medicaid program is $150.00 or more, vision training devices, repairs and/or replacement for which the charge is over $15.00, optical tints, high index lenses, special base curve, and all other appliances or items that are not listed in N.J.A.C. 10:62-3.4 or require an additional charge above that indicated in N.J.A.C. 10:62-3.4.

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The text at subsection (e) has been amended to incorporate the specific approval requirements of the Garden State Health Plan regarding the rendering of optical appliance services to members of this plan.

N.J.A.C. 10:62-2.6

There are several codification changes in this section. N.J.A.C. 10:62-2.6(a) and (b) remain the same. N.J.A.C. 10:62-2.6(c) is being deleted because it has been expressed in N.J.A.C. 10:62-2.5(d)5 in this proposed text. Subsequent subsections of this section are being recodified, accordingly. N.J.A.C. 10:62-2.6(d), (e) and (f) have been recodified as subsection (c), (d) and (e) to ensure proper codification. N.J.A.C. 10:62-2.6(f) sets forth the list of conditions for which the Division provides contact lenses. There is new language indicating that replacement of a contact within two years is allowed only if there has been a significant change in basic lens parameters. Prior authorization is required pursuant to N.J.A.C. 10:62-2.5. The existing text of N.J.A.C. 10:62-2.6(h), (i) and (j) has been recodified as subsection (g), (h) and (i) with minor clarifying language. N.J.A.C. 10:62-2.6(j) and (k) have been added with this readoption to describe the procedures for providing polycarbonate lenses and ultraviolet filter lenses.

The existing text of N.J.A.C. 10:62-2.6(k) has been recodified as N.J.A.C. 10:62-2.6(l) with a minor change in text. The word "lenses" has been deleted.

N.J.A.C. 10:62-2.7

Text of this section remains essentially unchanged, although subsection (b) is being deleted because it has not been apropriately placed in this section. The provision is covered by N.J.A.C. 10:62-2.5(d)4.

N.J.A.C. 10:62-2.8 through 2.10

The text of these sections has not been changed.

N.J.A.C. 10:62-2.11

The text of this section has been augmented by two additional data requirements for provider documentation of services, invoices from fabricating laboratory and material purchases, and supportive statements and reports, such as fire reports and police reports by way of substantiating the need for replacement of glasses or other optical appliances.

N.J.A.C. 10:62-2.12

The subsections N.J.A.C. 10:62-2.12(a) and (b) are new material indicating that providers must follow the instructions in the Fiscal Agent Billing Supplement and use the HCPCS codes when submitting a claim to Medicaid.

The existing language in N.J.A.C. 10:62-2.12(a) concerning the definition and use of actual invoice cost, with the addition of a provision for a dispensing fee, is being moved to N.J.A.C. 10:62-2.12(c). The existing 10:62-2.12(b) concerning the need to submit an invoice from the fabricating laboratory is being deleted, although paragraph 10:62-2.11(b)(7) has been added to indicate this must be maintained in the provider's patient records. The existing subsections N.J.A.C. 10:62-2.12(c), (d) and (e) have been recodified as N.J.A.C. 10:62(d), (e) and (f) respectively, with no change in text. Subsection N.J.A.C. 10:62-2.12(g) contains minor corrections to the current text. The existing subsection N.J.A.C. 10:62(f) has been recodified as N.J.A.C. 10:62(h). We are deleting the provision that specified that the provider is eligible for reimbursement when the recipient has lost eligibility for Medicaid between the time of ordering the appliance and the date of dispensing because this provision is covered by N.J.A.C. 10:62-2.5(c).

N.J.A.C. 10:62-3

The current subchapter on billing procedures is being repealed in its entirety. These procedures for submission of claims are not being utilized.

New billing procedures for submitting a claim to Paramax/Unisys are described in the Fiscal Agent Billing Supplement, Appendix A. The requirements for timely claim submittal are now located at N.J.A.C. 10:49-7.

The current text of N.J.A.C. 10:62-4 is entitled HCFA Common Procedure Coding System (HCPCS) and consists of an Editor's note indicating that the HCPCS are referenced, but not reproduced in the New Jersey Administrative Code, and the means of obtaining them.

This readoption publishes the complete text of the HCPCS codes that are used for vision care services as a new subchapter 3. The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding sysem. There are three levels of codes known as Level I, II, and III.

Level I Codes are adapted from CPT-4, for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

Copyright law prohibits the printing of excerpts from CPT-4 procedure narrative for Level I codes. Thus, in order to determine those narratives it is necessary to refer to the CPT-4, which is published by the American Medical Association and available from the AMA Order Department, P.O. Box 109050, Chicago, Illinois 60610.

Level II Codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4. Level II codes are listed in N.J.A.C. 10:62-3.4.

Level III codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey. These codes are listed in N.J.A.C. 10:62-3.5.

The HCPCS procedure codes listed in this Subchapter are divided into two sections: HCPCS procedure codes for professional services are in N.J.A.C. 10:62-3.3; and HCPCS procedure codes for vision care appliances are in N.J.A.C. 10:62-3.6.

Social Impact

This proposed readoption with amendments does not impose new responsibilities upon Medicaid recipients who need vision care services, including examination(s) and/or corrective devices. Removal of prior authorization in connection with many vision care procedures will allow services to be furnished more promptly, thereby being more responsive to the needs of Medicaid recipients.

The rules as amended impact on providers of vision care services, including ophthalmologists, optometrists, opticians and ocularists. The rules explain the provider qualifications, services they can render, including those that require prior authorization, and basis of reimbursement, and allow for the provision of vision care services to Medicaid recipients.

Economic Impact

There is no cost to the Medicaid recipient for vision care services. Cost to providers are as outlined in the Regulatory Flexibility Analysis below. Providers will be paid according to the fee schedules associated with the appropriate HCPCS code. The Division of Medical Assistance and Health Services spent approximately $6.2 million (Federal-State share combined) in State Fiscal Year 1993 for optical appliances and optometric exams combined. Some services provided by ophthalmologists are not included in this total, as they are reported as physicians' services.

The amended rules reflect changes in reimbursement that were previously made to certain codes, such as trifocals, in order to realign the fee structure for professional services, consistent with the fee increase that was granted in 1988. These changes are budget-neutral and do not reflect a current fee increase.

One of the amendments will require providers to use appropriate procedure coding, that is, to indicate the specific services billed for instead of billing for a generic "office visit."

Regulatory Flexibility Analysis

Some providers of vision care services would be considered small businesses under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:16. Therefore, a regulatory flexibility analysis is required.

All providers are required to maintain certain records to fully disclose the name of the patient, date the service was rendered, nature of the service, and other information. This requirement is contained in N.J.A.C. 10:62-1.12 and is based on N.J.S.A. 30:4D-12. The recordkeeping policies apply to all providers, regardless of size. This requirement is necessary to insure the health, safety, and well-being of the Medicaid patients receiving vision care services.

These proposed rules do continue the requirements that providers be qualified to perform the respective examinations, treatment, and services on behalf of Medicaid recipients. All providers must meet licensure and/or other qualifications established by State law. The rules recognize those legal requirements governing practice.

Providers are not required to hire additional professional staff to submit claims, but they may choose to do so.

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There are no capital costs associated with this proposal.

The rules are designed to minimize the adverse effect upon small business by either eliminating the need for prior authorization, or making the conditions less frequent. The Division has retained the requirements for low vision work-up and training because it still believes there is a need to prior authorize these procedures, which can be extensive and costly.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:62-3 and 4.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:62.

Full text of the amendments and proposed new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. EYE CARE: PROFESSIONAL SERVICES

10:62-1.1 Scope [and purpose of vision care professional services manual]

This subchapter delineates **the New Jersey Medicaid program's** standards for examinations and care for vision defects and/or eye diseases [provided by the New Jersey Medicaid Program] for the purpose of maintaining or improving the [public] health of [patients eligible for Medicaid in] New Jersey **Medicaid recipients.**

10:62-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Ophthalmologist" means [fully licensed medical doctor] **a licensed medical doctor who is a diplomate in the American Board of Ophthalmology and** who has been recognized by the New Jersey Medicaid [P]program as a specialist in ophthalmology.

"Optometrist" means any person who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or similarly licensed by a comparable agency of the State in which he or she performs such functions.

["Physician" means a licensed health care practitioner, including ophthalmologists and optometrists, acting within their scope of licensure.]

"Practitioner" means a licensed ophthalmologist or optometrist, acting within the scope of licensure.

"Transfer" means the relinquishing of responsibility for the continuing care of the [patient] **recipient** by one [physician] **practitioner** and the assumption of such responsibility by another [physician] **practitioner.**

10:62-1.3 Providers of **professional** services

(a) Within the restrictions of their respective licensure, the following are eligible providers of eye care **upon fulfilling the enrollment process requirements in N.J.A.C. 10:49-3.2**:

1. Ophthalmologists or optometrists licensed in the State of New Jersey;

2. [An] **O**phthalmologists or optometrists in another state who [is] **are** duly licensed in that state;

3. Independent [outpatient health care facilities] **clinics** approved by the New Jersey Medicaid [P]program to render eye care services; **and**

4. Hospitals meeting the definition of "approved hospital" as described in N.J.A.C. **10**:52-1.1 of the Hospital Services Manual.

10:62-1.4 Covered services

Professional services include **office visits for evaluation and management,** comprehensive eye examinations, [routine office visit, follow-up visit] low vision examinations, low vision work-ups, [and] vision training **work-ups, vision training program visits as well as other specific procedures as listed at N.J.A.C. 10:62-3.2.** Payment is made subject to the limitations specified under each type of service. If a service requires prior authorization, see N.J.A.C. 10:62-1.10.

[10:62-1.6 Routine office visit or follow-up visit

(a) Routine office visit or follow-up visit is defined as the care and treatment by a physician, which includes those procedures, ordinarily, performed during a health care visit, which is dependent upon the setting and the physician's discipline. In order to document the record for reimbursement purposes, the following shall be included, as a minimum, and documented on the provider's office record:

1. Purpose of visit;

2. Pertinent history obtained;

3. Pertinent physical findings including positive and negative physical findings based on (a)1 and 2 above;

4. Document all procedures performed and record respective data;

5. Lab, x-ray and ECG, etc. ordered, with results;

6. Diagnosis(es); and

7. Recommendations.]

10:62-[1.7]**1.6** Low vision examination

A low vision examination **as defined in N.J.A.C. 10:62-3.3** may be performed following a comprehensive eye examination when the vision in the better eye is 20/70 or less with the best correction.

10:62-[1.8]**1.7** Low vision work-up [(prior authorization required)]

A low vision work-up **as defined in N.J.A.C. 10:62-3.3** requires prior authorization **(see N.J.A.C. 10:62-1.9).** For purposes of the New Jersey Medicaid [P]program, a low vision work-up consists of certain testing techniques and procedures to determine what optical aids and devices can be prescribed for an individual to increase range of vision. A low vision work-up **requires a written report and** is much more detailed than the low vision examination **that** [following] **follows** a complete comprehensive examination [and requires a written report].

10:62-[1.9]**1.8** Vision training **program** [(prior authorization required)]

(a) Vision training requires prior authorization **(see N.J.A.C. 10:62-1.9).** For purposes of the New Jersey Medicaid [Program] **program**, vision training is the use of certain procedures and modalities for the development of and/or increase in the vision capacity of the eye(s) with poor and/or inconsistent or distorted vision localization.

(b) (No change.)

(c) If vision training is required following the initial comprehensive eye examination, the [physician] **practitioner** shall submit a written request **(form FD-358)** to Vision Care Unit for prior authorization **(see N.J.A.C. 10:62-1.9)** for a vision training work-up. This request shall include the preliminary findings, detailed reason(s) why it is believed a further evaluation is needed, and any history of previous vision training with the dates and the results. Upon receiving approval for a vision training work-up, the [physician] **practitioner** shall then submit, within 30 days of receipt of authorization, the work-up report to the Vision Care Unit. The vision training work-up report shall consist of, but not be limited to:

1.-6. (No change.)

(d) The decision of the Vision Care Unit to approve or deny vision training will be transmitted to the practitioner by the fiscal agent.

[(d)]**(e)** Upon completion of an approved training program, the [physician] **practitioner** shall submit a detailed progress report, listing the status of all parameters indicated in the original evaluation. No treatment plan shall exceed a period of 90 days or a total of 30 training visits, commencing with the inception of the treatment plan. [Prior] **An additional prior** authorization is required for any extension of treatment and requires submission of a detailed progress report **to the Vision Care Unit.**

[(e)]**(f)** Vision training may be provided by a [private physician. Vision training may also be provided,] **practitioner when found medically necessary. This service can be performed in the office or** [when a professional multi-disciplinary evaluating team indicates this need,] in a [licensed or certified health care facility or a "special clinic"] **independent clinic** approved by the New Jersey Medicaid [Program] **program.**

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10:62-[1.10]**1.9** Professional services requiring prior authorization

(a) [Prior authorization shall be requested in writing from the Vision Care Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, for the services listed under (c) below.] **Form FD-358 (Request for Prior Authorization for Vision Care Services) shall be used to request prior authorization for professional services. Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form, clearly indicating the reasons for requesting the service requiring prior authorization, shall be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code #16, CN 712, Trenton, New Jersey 08625-0712. When a request for prior authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.**

(b) [The written request shall be made before the service is provided and should include proper recipient identification, the diagnosis and detailed reasons why such services are being requested.] **Items requiring prior authorization should not be provided to the Medicaid recipient until the authorization is received by the provider from the fiscal agent.**

(c) The following professional services require prior authorization:

[3.]**1. Low vision work-up;**

2. Vision training **program;**

[1.]**3.** Vision training work-up; **and**

4. (No change.)

(d) [If a request for authorization is denied, the provider shall be notified of the reason, in writing, by the Vision Care Consultant.] **Vision care provider services rendered to Medicaid recipients who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. (See N.J.A.C. 10:49-19 and 10:49-20 for specifics on prepaid health plans, the Garden State Health Plan, which serves the Medicaid population, and the Fiscal Agent Billing Supplement, for details for obtaining prior authorization.**

10:62-[1.11]**1.10** Prescription policies

(a) [A patient is entitled to have a copy of his or her prescription for eye-glasses. To prevent possible recipient overutilization, the] **Upon request, a recipient must be provided with his or her prescription for an optical appliance. The** following information shall be indicated on the prescription: Name, address, HSP (Medicaid) Case Number, date of examination**, and diagnosis code(s)**.

(b) If a [patient] **recipient** requests a duplicate prescription [from a non-dispensing provider (Ophthalmologist or Optometrist)], the duplicate prescription shall clearly indicate: **"THIS IS A DUPLICATE".** ["This is a duplicate of the original prescription".] The date of the original prescription shall also be included. **The dispensing provider shall retain the original prescription.**

[(c) The dispensing provider (Ophthalmologist or Optometrist or Optician) shall retain the original prescription. If a duplicate is requested by the patient, specify on the duplicate that it is a duplicate of a prescription, indicating the date that the glasses were dispensed.]

10:62-[1.12]**1.11** Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. Data shall include such quantitative positive and negative findings as will be meaningful in **a** subsequent review. Check marks are not acceptable. The information shall be readily available to representatives of the New Jersey Medicaid [P]program, or its agents, as required.

(b) (No change.)

10:62-[1.13]**1.12** [Basic for] Reimbursement **policies**

(a) Instructions for submitting claims for payment of vision care services are provided in the Fiscal Agent Billing Supplement.

(b) Vision care services shall be identified by means of procedure codes, utilizing the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

[(a)]**(c)** The provider shall use his or her usual and customary charge when submitting a claim **for vision care services.** Reimbursement for covered services furnished under the New Jersey Medicaid [P]program shall be made on the basis of the **provider's** customary charge, not to exceed an allowance determined to be reasonable by the Commissioner of the Department of Human Services, and further limited by federal policy (policy 42 CFR 447 Subpart B) relative to payment of [practitioners] **practitioners** and other individual providers.

1. In no event shall the charge to the New Jersey Medicaid [P]program exceed the charge by the provider for identical services to other governmental agencies, private nonprofit agencies, trade unions or other individuals in the community.

2. If a [patient] **recipient** receives care from more than one member of a partnership or corporation in the same discipline **for the same service,** the maximum payment allowance shall be the same as that of a single provider. For purposes of reimbursement, optometrist and/or physician, optometrist and physician groups, shared health care facility, or optometrist and physician sharing a common record shall be considered a single provider.

3. (No change.)

[(b)]**(d)** For reimbursement purposes, when the [physician] **practitioner** submits a claim for [the following] services, the services shall have been performed personally by the [physician] **practitioner** submitting the claim[:].

[1. Office visit;

2. Hospital visit;

3. Long-term care facility visit or residential health care facility visit;

4. Any and all parts of the history or eye examination, as may be required under the rules of the physician's licensing board.]

[(c)]**(e)** To qualify as documentation that the service was rendered by the [physician] **practitioner** during an inpatient stay, the **recipient's** medical record must contain the [physician's] **practitioner's** notes indicating that he or she personally:

1. Reviewed the [patient's] **recipient's** medical history with the [patient] **recipient** and/or his or her family, depending upon the medical situation;

2. Performed an eye examination**, or other procedure**;

3. **Established,** confirmed or revised the diagnosis; **and**

4. Visited and examined the [patient] **recipient** on the day(s) for which a claim for reimbursement is made.

[(d) The billing physician's involvement must be clearly demonstrated on notes reflecting his or her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A countersignature alone is not sufficient.]

[(e) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS) (see N.J.A.C. 10:62-4, Subchapter 4 of this manual, for details).

1. Dates of service for each procedure code submitted for reimbursement must be indicated on the claim form and the physician's own office record.]

SUBCHAPTER 2. OPTICAL APPLIANCES AND SERVICES

10:62-2.1 Scope [of optical appliances and services]

This subchapter covers the provision of optical appliances necessary for the correction of any eye vision defects.

10:62-2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

. . .

"Optical appliances" mean[s] those items, devices or appliances prescribed by [an eligible provider and furnished by an eligible provider] **a practitioner** in order to aid or improve vision, or to replace the eye.

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"Optician" means an individual licensed by the **New Jersey** State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, **or similarly licensed by a comparable agency of the state in which he or she performs such function.**

["Providers of optical appliances" means those providers who possess New Jersey licensure for supplying optical appliances to the public, and are approved by the New Jersey Medicaid program.]

10:62-2.3 Providers of **optical appliances and other** services

(a) Within the restrictions of their respective licensure, the following are [the only providers eligible to participate in the Vision Care Program] **eligible providers upon fulfilling the Enrollment Process requirements in N.J.A.C. 10:49-3.2;**

1. [Persons licensed by the State of New Jersey to practice medicine and defined in N.J.A.C. 10:62-1.2 as ophthalmologists] **Ophthalmologists as defined in N.J.A.C. 10:62-1.2;**

2. [Persons licensed by the State of New Jersey to practice optometry] **Optometrists as defined in N.J.A.C. 10:62-1.2;**

3. [Persons licensed by the State of New Jersey as ophthalmic dispensers] **Opticians as defined in N.J.A.C. 10:62-2.2;**

4. Ocularists as defined in N.J.A.C. 10:62-2.2;

[4.]**5.** Independent [outpatient health care facilities] **clinics** approved by the New Jersey Medicaid [P]program to render eye care services;

[5.]**6.** Hospitals approved by the New Jersey Medicaid [Program] **program for** participation; and

[6.]**7.** [An ophthalmologist] **Ophthalmologists,** optometrists or opticians in another state who [is] **are** duly licensed or meet[s] the requirements of [his or her] **their** own state with regard to the dispensing of optical appliances **within that state.**

[(b) Persons recognized as ocularists may be considered providers of artificial eyes, upon recommendation of the prescribing practitioner and prior approval by the New Jersey Medicaid program.]

10:62-2.4 Covered services

The following optical appliances **and services** are covered under the New Jersey Medicaid [P]program:

1.-2. (No change.)

3. Repairs of optical appliances (prior authorization required for repairs [over $5.00] **for which the charge to the Medicaid program is $15.00 or over** (see N.J.A.C. 10:62-2.5);

4. Artificial eyes ([prior authorization required, see N.J.A.C. 10:62-2.5] **may be provided once every three years when prescribed by an ophthalmologist or an optometrist**);

5. Low vision devices (prior authorization required **if the total charge to the Medicaid program is $150.00 or more,** see N.J.A.C. 10:62-2.5);

6. Vision training devices (prior authorization required, see N.J.A.C. 10:62-2.5);

7. Replacement of optical appliances [(prior authorization required, see N.J.A.C. 10:62-2.5);]**:**

i. Lenses and frames may be replaced once every two years for persons age 19 through and including 59 years of age, and once a year for persons less than 19 years or 60 years of age and older, provided there is a change of 0.50 diopter in sphere and or cylinder power, or a change of five degrees or more in cylinder axis.

ii. Lenses may be replaced more frequently than once every two years for persons 19 through and including 59 years of age or more frequently than once every year for persons less than 19 years or 60 years of age and older, providing there is a prescription change of at least 0.75 diopter in spherical and/or cylindrical power or a change in axis of eight degrees or more. Providers shall enter the previous prescription number in the Remarks section (#19) of the MC-9 claim form.

iii. When an optical appliance is destroyed in a fire or stolen, the provider shall place a written statement in the Remarks section (#19) of the MC-9 claim form and put a copy of the fire/police report in the provider's recipient file.

iv. Providers may provide one replacement of frame and/or lenses per year for individuals with developmental disabilities. Providers shall place a written supporting statement and diagnosis related information in the Remarks section (#19) of the MC-9 claim form and put a copy of the developmental disabilities report in the provider's recipient file.

8. Dual pairs of glasses instead of multifocal (prior authorization required, see N.J.A.C. 10:62-2.5);

9. Contact lenses [(prior authorization required, see N.J.A.C. 10:62-2.5)]; **and**

10. Intraocular lenses.

10:62-2.5 Optical appliances requiring prior authorization

(a) Form MC-9(**A**) (Request for Authorization and Payment—Optical Appliances) shall be used for requesting prior authorization **for optical appliances.** [The completed form, indicating clearly the reasons for requesting prior authorization, shall be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625.] **Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form clearly indicating the reasons for requesting the appliance requiring prior authorization, must be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code #16, CN712, Trenton, New Jersey 08625-0712. When a request for authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.**

(b) Items requiring prior authorization should not be provided to the Medicaid [patient] **recipient** until the authorization is received by the provider. (Reference is made to N.J.A.C. 10:49-6).

(c) Authorization becomes invalid upon termination of eligibility for the New Jersey Medcaid [P]program, except when the termination occurs between the time the optical appliance is ordered and the time the optical appliance is dispensed. **Note: The provider shall use the date the optical appliance is ordered as the date of service when this situation occurs.)**

(d) The following optical appliances require prior authorization:

[1. Contact lenses;]

[2. Artificial eyes;]

[3.]**1.** Low vision devices **when the total charge to the Medicaid program is $150.00 or more;**

[4.]**2.** Vision training devices;

[5.]**3.** Repair of an optical appliance [exceeding $5.00] **when the charge to the Medicaid program is $15.00 or more;**

[6.]**4.** Replacement of optical appliances;

i. [The New Jersey Medicaid program shall no longer pay for replacement of optical appliances which may have been lost, broken, damaged or stolen unless prior authorized.] **In circumstances not covered in N.J.A.C. 10:62-2.4, the replacement of an optical appliance requires prior authorization. For example: If lost, broken and irreparable, or prescription change is less than 0.50 diopter or 5 degrees in axis.**

[ii. If prior authorization is approved due to extenuating circumstances, the replacement appliance shall be identical to the appliance being replaced.]

[7.]**5.** Dual pairs of glasses instead of multifocal[:]**;**

[i. A physician's statement indicating medical necessity shall be submitted when requesting two pairs of glasses in lieu of multifocal lenses.

8. When optical appliances are requested more than once every two years for persons 19 through 59 years of age or more frequently than once a year for persons less than 19 years or over 60 years:

i. To justify the request, all subsequent prescriptions shall have a change of at least 0.50 diopter in spherical or cylindrical power or a change in axis of five degrees or more.]

[9.]**6.** Optical tints (except [pink] **rose,** one and two, [or gray] **grey or** [and] brown plastic lenses 10 percent to 20 percent);

[10.]**7.** High index lenses;

[11.]**8.** Special base curve; and

[12.]**9.** All other optical appliance items [not listed or] requiring additional charges or not identified in N.J.A.C. 10:62-[4.4]**3.4** ([Subchapter 4,] HCPCS **Procedure** Codes [Numbers] and Maximum Fee Schedule for Vision Care Appliances).

(e) [If a request for authorization is denied, the provider shall be notified of the reason, in writing, by the Vision Care Consultant.]

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Optical appliance services rendered to Medicaid recipients who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. See N.J.A.C. 10:49-19 and 10:49-20 for specifics on prepaid health plans and the Garden State Health Plan which serve the Medicaid population and the Fiscal Agent Billing Supplement for details for obtaining prior authorization.

10:62-2.6 Standards and policies regarding lenses

(a) Lenses shall be first quality ophthalmic lenses meeting the requirements published by American National Standard Institute **(available from the American National Standards Institute, 11 West 42 St., New York, N.Y. 10036, tel. 212-642-4900.**

(b) Safety lenses shall meet impact resistant standards as set forth in **the** United States Food and Drug Administration regulations (21 CFR 3.84).

[(c) When the prescription for proper distance vision is different from the prescription necessary for normal wear vision, bifocals and/or multifocal lenses are recommended. If two pairs of lenses are needed, see N.J.A.C. 10:62-2.5(d)7.]

Recodify (d)-(f) as **(c)-(e)** (No change in text.)

[(g)]**(f)** Contact lenses [(prior authorization required as indicated in N.J.A.C. 10:62-2.5)] may be [approved only when recommended] **provided** for:

1. Specific ocular pathological conditions (for example, Keratoconus, monocular surgical aphakia to effect binocular vision**, anisometropia of 3.0 diopters or more**;

2. Patients whose vision cannot be improved to at least 20/70 with regular lenses but improvement of vision can be accomplished to 20/70 or better [in the better eye]**; and**

3. Replacement of a contact lens within two years is allowed only if there has been a significant change in basic lens parameters (design or prescription) prior authorization is required, see N.J.A.C. 10:62-2.5.

[(h)]**(g)** The policy for duplication or reproduction of the same correction is as follows:

1. A re-examination and new prescription are required if more than one year (or two years in the case of an individual [between] 19 [and] **through and including** 59 years of age) has elapsed since the date of the original prescription.

[2. The provider shall determine date and type of previous vision care service.]

[(i)]**(h)** The New Jersey Medicaid [P]program will not pay for replacement of optical appliances which may have been lost, broken, damaged or stolen unless prior authorized.

[(j)]**(i)** Prior authorization is required for individuals with significant pathological conditions requiring optical tints other than [pink] **rose**, one and two, [or] grey or brown plastic lenses 10 percent to 20 percent.

(j) Polycarbonate lenses may be provided in special situations when maximum protection is indicated and recommended in writing by the prescribing practitioner.

(k) Ultraviolet filter lens may be provided in special situations when maximum ultraviolet protection is indicated for the preservation of tissue integrity and recommended in writing by the prescribing practitioner.

[(k)]**(l)** The following [lenses] are not covered under the New Jersey Medicaid [P]program:

1.-6. (No change.)

10:62-2.7 Standards and policies regarding frames

(a) Plastic, non-flammable frames acceptable to the New Jersey Medicaid [P]program shall meet the following minimum criteria:

1.-6. (No change.)

[(b) Replacement of a frame within two years is allowed only if the frame is lost, or broken and not repairable, and if prior authorized.]

[(c)]**(b)** Wire-metal frames are not covered under the New Jersey Medicaid [Program]**program**.

10:62-2.10 Approved fabricating laboratory

(a) For purposes of the New Jersey medicaid [P]program, an approved fabricating laboratory shall have the necessary equipment, licensed personnel and capability to completely surface and finish new optical glass or plastic lenses or partially finished lenses.

(b) The laboratory shall be able to provide all services necessary to completely furnish[ed] eyeglasses as may be requested by an optical dispenser and is subject to approval by the New Jersey Medicaid [Program] **program**. A provider may call the Vision Care Unit (609-588-2729) to ascertain if a laboratory is Medicaid approved.

10:62-2.11 Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services**, which are subject to post audit review**. Such information shall be readily available to the representatives of the New Jersey Medicaid [P]program or its agents as required.

(b) The records **as** required by (a) above shall include the following [data]:

1.-4. (No change.)

5. Date of the prescription received; [and]

6. (No change.)

7. Invoice from fabricating laboratory and material purchase invoices, as applicable; and

8. All supportive statements and reports, for example fire report, police report, developmental disabilities, medical necessity, etc.

(c) (No change.)

10:62-2.12 [Basis for reimbursement] **Reimbursement policy**

(a) Instructions for submitting claims for payment of optical appliances are provided in the Fiscal Agent Billing Supplement.

(b) Optical appliances must be identified by means of procedure codes, utilizing the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

[(a)]**(c)** The reimbursement policy of the New Jersey Medicaid [Program] **program** provides for payment to the provider of the actual invoice cost of the optical appliance **plus a dispensing fee**. Providers are requested to indicate the actual invoice cost of the material when submitting a claim. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. The service (dispensing) fee, to which the provider is entitled, should be indicated as a separate item.

[(b) When submitting a claim for reimbursement, the fabricating laboratory invoice (see N.J.A.C. 10:62-2.10), when applicable, shall be attached to the claim form MC-9.]

[(c)]**(d)** The maximum allowable reimbursement for frames is not to exceed an allowance determined to be reasonable by the Commissioner, Department of Human Services. However, providers shall only bill the New Jersey Medicaid [Program] **program** for the actual invoice cost of the frame when submitting a claim for payment. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. Frames are reimbursable only if they meet the criteria listed in N.J.A.C. 10:62-2.7.

[(d)]**(e)** Optical appliances are reimbursable under the New Jersey Medicaid [Program] **program** only when prescribed by a provider of professional eye services as defined in N.J.A.C. 10:62-1.3[, that is, physicians recognized by the Program as ophthalmologists, optometrists, approved independent eye clinics and hospitals, and when dispensed by a provider of optical appliances as defined in N.J.A.C. 10:62-2.2].

[(e)]**(f)** Non-physician services and equipment/supplies furnished to hospital inpatients by outside providers shall not be billed directly to the New Jersey Medicaid [Program] **program**. Providers shall submit a bill/invoice to the hospital for payment.

(g) The cost of intraocular lenses is reimbursable to hospitals or ambulatory surgical centers where the surgery is performed or directly to the ophthalmologist.

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1. Ophthalmologists may be reimbursed for **the cost of** the intraocular lenses, [providing payment is not made to] **provided that reimbursement is not requested by** the hospital or the ambulatory surgical center. To be reimbursed, the ophthalmologist shall complete the MC-9 form [and attach the purchase invoice, supplied by the lens manufacturer,] and mail it to the [Vision Care Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625] **fiscal agent.**

[(f)]**(h)** Reimbursement by the New Jersey medicaid [P]program shall be made for covered services provided to eligible recipients only[; however, if the Medicaid recipient becomes ineligible between the time the optical appliance is ordered and the time the optical appliance is dispensed, the service is still eligible for reimbursement].

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:62-3.1 Introduction

(a) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (Narratives found in CPT-4): These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narrative for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented. (The CPT-4 is available from the Order Department of the American Medical Association, P.O. Box 109050, Chicago, Illinois 60610.)

2. Level II Codes (Narratives found in N.J.A.C. 10:62-3.5): These codes are assigned by HCFA for physician and non-physician services which are not in CPT-4.

3. Level III Codes (Narratives found in N.J.A.C. 10:62-3.3 and 3.5): These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) The HCPCS procedure codes listed in this subchapter are divided into two sections: HCPCS procedure codes for professional services are in N.J.A.C. 10:62-3.2; and HCPCS procedure codes for vision care appliances are in N.J.A.C. 10:62-3.5.

(c) The responsibility of the provider when rendering professional services and requesting reimbursement is listed in N.J.A.C. 10:62-1 (Reimbursement Policies); for optical appliances, N.J.A.C. 10:62-2 (Reimbursement Policies).

1. When filing a claim, the appropriate HCPCS procedure codes must be used in conjunction with the modifiers when applicable.

2. The use of a HCPCS procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, at a minimum, the service which the code represents.

3. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the practitioner submitting the claim:

i. Office, hospital, nursing home, or residential health care facility visits; and

ii. Any and all parts of a history or eye examination.

4. To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record must contain the practitioner's notes indicating that he/she personally:

i. Reviewed the patient's medical history with the patient and/or his/her family, depending upon the medical situation;

ii. Performed an eye examination;

iii. Confirmed or revised the diagnosis; and

iv. Visited and examined the patient on the day(s) for which a claim for reimbursement is made.

5. Date(s) of service(s) must be indicated on the claim form and in the practitioner's own record for each service billed.

6. When submitting a claim, the practitioner must always use his/her usual and customary fee. The Medicaid dollar value designated for the HCPCS procedure codes represents the New Jersey Medicaid program's maximum payment for the given procedure.

i. All references to time parameters shall mean the practitioner's time in reference to the service rendered unless it is otherwise indicated.

(d) Regarding specific elements of HCPCS procedure codes which require[s] attention of providers, the lists of HCPCS procedure codes for vision care services are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", AND "MAXIMUM FEE ALLOWANCE". The information identified under each column is summarized below:

COLUMN TITLE	
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer a provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure and service code is used. Explanation of indicators and qualifiers used in this column are identified below: "L" preceding any HCPCS procedure code indicates that the complete narrative for the HCPCS procedure code is located in N.J.A.C. 10:62-3.3. "N" preceding any HCPCS procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by HCPCS procedure code in N.J.A.C. 10:62-3.4. "P" preceding any HCPCS procedure code indicates that prior authorization is required. (See N.J.A.C. 10:62-1. and 2.) "R" preceding any HCPCS procedure code indicates a HCPCS procedure code for a factor necessary in the fabrication of a lens prescription. For proper reimbursement, the code must be listed on the claim form (MC-9) in addition to the basic lens code.
HCPCS CODE	Lists the HCPCS procedure code for professional services and vision care appliances.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the HCPCS procedure code. The New Jersey Medicaid program's recognized modifier codes for vision care services are as follows:

MODIFIER CODE	DESCRIPTION
YF	Optical Frame Service Fee: To be used when patient supplies his or her own Medicaid plastic frame.
22	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure code and enclose a copy of the invoice. When billing, a copy of the invoice is required. (See "Comprehensive Eye Examination with Diagnostic Fields" in N.J.A.C. 10:62-3.4.)
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the

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modifier "52" signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic services. This also applies when using Stock Bifocals. (See "Bifocal Lenses, Glass or Plastic" in N.J.A.C. 10:62-3.5(d)).

DESCRIPTION

Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found in N.J.A.C. 10:62-3.2 and 3.5.

MAXIMUM FEE ALLOWANCE Lists New Jersey Medicaid program's maximum reimbursement schedule. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that the service is not reimbursable.

(e) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because, in certain instances, requirements are created in addition to the narrative which accompanies the HCPCS procedure code as written in CPT-4. The provider must be careful to enter the additional requirements, and not just the HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the HCPCS procedure code narrative prevails.

(f) For surgical codes relevant to Ophthalmologists see Physicians Services Chapter (N.J.A.C. 10:54-4, HCFA Common Procedure Coding System).

10:62-3.2 HCPCS Procedure Codes and maximum fee schedule for professional vision care services

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE
	65205		$16.00
	65210		32.00
	65220		32.00
	65222		48.00
	65430		16.00
	67820		16.00
	68800		8.00
N	92002		22.00
N	92004		22.00
N	92004	22	26.00
N	92012		22.00
N	92014		22.00
N	92014	22	26.00
	92018		35.00
	92019		35.00
N	92020		16.00
	92060		N.A.
P-N	92065		16.00
	92070		N.A.
N	92081		16.00
N	92082		16.00
N	92083		16.00
N	92100		16.00
N	92120		16.00
N	92130		16.00
N	92140		16.00
	92225		25.00
	92226		21.00
	92235		53.00
	92250		10.00
N	92260		15.00
	92265		25.00
	92270		11.00
	92275		20.00
N	92280		45.00
	92286		12.00
	92310		N.A.
	92311		N.A.
	92312		N.A.
	92313		N.A.
	92314		N.A.
	92315		N.A.
	92316		N.A.
	92317		N.A.
	92325		N.A.
	92326		70.00
	92330		N.A.
	92335		N.A.
	92340		N.A.
	92341		N.A.
	92342		N.A.
	92352		N.A.
	92353		N.A.
	92354		N.A.
	92355		N.A.
	92358		N.A.
	92370		N.A.
	92371		N.A.
	92541		5.00
	92542		8.00
	92544		5.00
	92545		5.00
N	99201		16.00
N	99202		16.00
N	99211		16.00
N	99212		16.00
N	99213		16.00
N	99214		16.00
N	99215		16.00
L	W9200		12.00
L-P	W9205		70.00
L-P	W9210		70.00
L-N	W9220		16.00

10:62-3.3 Professional vision care service codes and narratives not found in CPT-4 (Level II and Level III codes)

IND	HCPCS CODE	MOD	DESCRIPTION	MAXIMUM FEE ALLOWANCE
	W9200		Low Vision Exam, a continuation of a comprehensive eye exam, with limited additional tests to determine if low vision devices would benefit vision problems that cannot be normalized by conventional spectacles. NOTE: This low vision examination is used as an additional procedure at the time of the original examination.	$ 12.00

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P	W9205	Low Vision Work-up with written report. Prior Authorization required. This is a battery of extensive tests and independent procedures to determine a device or a combination of devices that would permit an individual to enhance visual functions.	70.00
P	W9210	Vision training workup and written report (prior authorization required).	70.00
N	W9220	Slit lamp examination	16.00

10:62-3.4 Qualifiers for professional vision care services

(a) Qualifiers for professional vision care services are summarized below:

HCPCS
CODES PROCEDURE

1. COMPREHENSIVE EYE EXAMINATION

92002
92004
92012
92014

Comprehensive Eye Examination—Codes 92002, 92004, 92012 or 92014 refer to a new or established patient respectively. For reimbursement purposes, the use of these codes requires as a minimum a comprehensive eye examination, one or more office visits, which shall include, with or without cycloplegics, and with or without a post cycloplegic visit, the following:

i. Detailed case history;
ii. External and internal (ophthalmoscopic) examination;
iii. Refraction (objective and subjective);
iv. Gross visual fields (central and peripheral);
v. Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified (that is, the finger palpation test is not acceptable);
vi. Binocular coordination testing (distance and near);
vii. The diagnosis (Ocular deficiency or deformity, visual or muscular anomaly, and so forth); and
viii. Recommendations.

2. COMPREHENSIVE EYE EXAMINATION WITH DIAGNOSTIC FIELDS

92004 22
92014 22

Comprehensive Eye Examination with Diagnostic Fields—Codes 92004 22 or 92014 22 refer to a new or established patient respectively. For reimbursement purposes, it shall include all the criteria of procedure codes 92002, 92004, 92012 or 92014 plus complete Diagnostic Visual Fields.

i. NOTE: These codes are not routinely reimbursable for complete comprehensive eye examination. Patients should be selected for this additional service based upon history and ophthalmologic findings during the examination; if the physical examination suggests the presence of optic or motor nerve abnormalities, or if other significant physical findings are present and documented, diagnostic visual field studies may be selectively employed to establish or to confirm the diagnosis and/or the degree of impairment.

ii. NOTE: A Comprehensive eye examination with or without diagnostic fields is limited to once a year.

3. INDEPENDENT OFFICE PROCEDURES

92020
92065
92081
92082
92083
92100
92120
92130
92140
92260
W9220

Independent Office Procedures—Codes 92020, 92065, 92081, 92082, 92083, 92100, 92120, 92130, 92140, 92260, W9220, are not reimbursable when performed on the same day as Codes 99201, 99202, 99211, 99212, 99213, 99214, 99215, 92002, 92004, 92012 or 92014. When multiple procedures are billed on the same day for the same patient in an office setting, reimbursement will be limited to the highest valued procedure.

4. OFFICE SERVICES (NEW PATIENT)

99201
99202

Codes 99201 and 99202 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

5. OFFICE SERVICES (ESTABLISHED PATIENT)

99211
99212
99213
99214
99215

Codes 99211, 99212, 99213, 99214, and 99215 are not reimbursable with 92002, 92004, 92012 or 92014 on the same day.

6. BRAIN-STEM-EVOKED RESPONSE TESTING

92280

Not reimbursable for initial testing, general screening, research studies or any situation where usefulness has not been clearly established; and therefore, it is without controversy.

Code 92280—for reimbursement purposes refers to a visual brain-stem-evoked response (VBR) with interpretation. Reimbursable to hospital outpatient department as a hospital charge or to a qualified provider (office setting). The study must be personally performed by any of the following disciplines trained and experienced with VBR testing, namely Ophthalmologists, Optometrists, Neurologists, Neurosurgeons, and Psychiatrists. Criteria for testing:

i. Inconclusive test results by standard vision testing for:
(1) Neonates and infants at risk for vision loss;
(2) Children and adults who cannot perform behavioral testing.
ii. Suspected organic neurologic lesion within or proximal to the visual pathway.

10:62-3.5 HCPCS Procedure Codes and maximum fee schedule for vision care appliances

IND	HCPCS CODE	MOD	DESCRIPTION	MAXIMUM FEE ALLOWANCE
(a) LENS DISPENSING FEE				
	Y5100		Lens Service (Cataract Bifocal over + or − 10 D)	$ 40.00
	Y5105		Lens Service (Cataract Single Vision over + or − 10 D)	20.00
	Y5110		Lens Service (Single vision lens)	12.00
	Y5112		Lens Service (Bifocal lens)	15.00
	Y5114		Lens Service (Trifocal lens)	17.00
(b) FRAMES				
	V2020		Frames, purchases	8.00
	Y5150		Frames, purchase, replacement (due to irreparable damage)	8.00
	Y9787		Repair of frames	15.00
			NOTE: Frame repairs charge $15.00 or more require prior authorization	
	Y5165		Frames, (dispensing fee)	8.00

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	Y5165	YF Frames, (dispensing fee) NOTE: YF—Patient supplied his or her own Medicaid plastic frame	8.00

(c) SINGLE VISION LENSES, GLASS OR PLASTIC

	V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	5.80
	V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00D, per lens	6.00
	V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00D, per lens	14.25
	V2103	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens	8.50
	V2104	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens	9.50
	V2105	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens	10.50
P	V2106	Spherocylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2107	Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	10.50
	V2108	Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere, 2.12D to 4.00D cylinder, per lens	11.50
	V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	12.50
P	V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens	13.50
	V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder, per lens	14.50
	V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens	15.50
	V2114	Spherocylinder, single vision, sphere over plus or minus 12.00D, per lens NOTE: With any cylinder	19.50
R	V2115	Lenticular, (myodisc), per lens, single vision	25.00
R	V2116	Lenticular lens, nonaspheric, per lens, single vision	35.00
R	V2117	Lenticular, aspheric, per lens, single vision	45.00
P	V2118	Aniseikonia lens, single vision	B.R.
P	V2199	Not otherwise classified, single vision lens	B.R.

(d) BIFOCAL LENSES, GLASS OR PLASTIC
(up to and including 28mm seg width, add power up to and including +4.00D)

	V2200	Sphere, bifocal, plano to plus or minus 4.00D per lens	12.00
	V2200 52	Sphere, bifocal, plano to plus or minus 4.00D, per lens—Stock lens	7.00
	V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens	14.25
	V2201 52	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens—Stock lens	7.00
	V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00D, per lens	18.85
	V2203	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens	13.50
	V2204	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens	14.50
	V2205	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens	15.50
P	V2206	Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2207	Spherocylinder, bifocal plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	18.60
	V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens	20.65
	V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	21.65
P	V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens	B.R.
	V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.00D cylinder, per lens	23.60
	V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens	25.60
	V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25D to 4.00D cylinder, per lens	25.60
	V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00D, per lens NOTE: With any cylinder	25.60
R	V2215	Lenticular (myodisc), per lens, bifocal	40.00
R	V2216	Lenticular, nonaspheric, per lens, bifocal	55.00
R	V2217	Lenticular, aspheric, per lens, bifocal	65.00
P	V2218	Aniseikonia, per lens, bifocal	B.R.
P	V2219	Bifocal seg width over 28mm	B.R.

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	V2220	Bifocal add over 3.25D NOTE: Per pair	15.00
P	V2299	Specialty bifocal	B.R.

(e) TRIFOCAL LENSES, GLASS OR PLASTIC
(up to and including 28mm seg width, add power up to and including 3.25D)

	V2300	Sphere, trifocal, plano to plus or minus 4.00D, per lens	19.50
	V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00D, per lens	21.75
	V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	26.35
	V2303	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, .12-2.00D cylinder per lens	21.00
	V2304	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25 to 4.00D cylinder, per lens	22.00
	V2305	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00 cylinder, per lens	23.00
	V2306	Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, over 6.00 cylinder, per lens	30.00
P	V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens	B.R.
P	V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens	B.R.
P	V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens	B.R.
P	V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens	B.R.
P	V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens	B.R.
P	V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens	B.R.
P	V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens	B.R.
P	V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00D cylinder, per lens NOTE: With any cylinder	B.R.
P-R	V2315	Lenticular, (myodisc), per lens, trifocal	B.R.
P-R	V2316	Lenticular nonaspheric, per lens, trifocal	B.R.
P-R	V2317	Lenticular, aspheric, per lens, trifocal	B.R.
P	V2318	Aniseikonia, per lens, trifocal	B.R.
P	V2319	Trifocal seg width over 28mm	B.R.
	V2320	Trifocal add over 3.25D NOTE: Per pair	15.00
P	V2399	Specialty trifocal	B.R.

(f) VARIABLE SPHERICITY LENSES
(Welsh 4 drop, hyperaspheric, double drop, etc.)

P	V2410	Variable sphericity lens, single vision, full field, glass or plastic, per lens	B.R.
P	V2430	Variable sphericity lens, bifocal, full field, glass or plastic, per lens	B.R.
P	V2499	Variable sphericity lens, other type	B.R.

(g) CONTACT LENSES

P	V2500	Contact lens, pmma, spherical, per lens	B.R.
P	V2501	Contact lens, pmma, toric or prism ballast, per lens	B.R.
P	V2502	Contact lens, pmma, bifocal, per lens	B.R.
P	V2503	Contact lens, pmma, color vision deficiency, per lens	B.R.
	V2510	Contact lens, gas permeable, spherical, per lens	120.00
P	V2511	Contact lens, gas permeable, toric, prism ballast, per lens	B.R.
P	V2512	Contact lens, gas permeable, bifocal, per lens	B.R.
	V2513	Contact lens, gas permeable, extended wear, per lens	120.00
	V2520	Contact lens hydrophilic, spherical, per lens	100.00
P	V2521	Contact lens hydrophilic, toric, or prism ballast, per lens	B.R.
P	V2522	Contact lens hydrophilic, bifocal, per lens	B.R.
	V2523	Contact lens hydrophilic, extended wear, per lens	100.00
P	V2530	Contact lens, scleral, per lens (for contact lens modification, see 92325)	B.R.
P	V2599	Contact lens, other type	B.R.

(h) LOW VISION AIDS

	V2600	Hand held low vision aids and other nonspectacle mounted aids	75.00
	V2610	Single lens spectacle mounted low vision aids	150.00
P	V2615	Telescopic and other compound lens system including distance vision telescopic, near vision telescopic and compound telescopic lens system	B.R.

(i) PROSTHETIC EYES

P	V2620	Prosthetic, eye, glass, stock	B.R.
	V2621	Prosthetic, eye, plastic, stock	300.00
P	V2622	Prosthetic, eye, glass, custom	B.R.
	V2623	Prosthetic, eye, plastic, custom	300.00
P	V2629	Not otherwise classified, prosthetic eye	B.R.

(j) INTRAOCULAR LENSES

	V2630	Anterior chamber intraocular lens	200.00
	V2631	Iris supported intraocular lens	200.00
	V2632	Posterior chamber intraocular lens	200.00

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(k) MISCELLANEOUS

	V2700		Balance lens, per lens NOTE: Single vision	5.00
	V2700	22	Balance lens, per lens NOTE: Bifocal	10.00
P	V2710		Slab off prism, glass or plastic, per lens	B.R.
	V2715		Prism, per lens	7.00
P	V2718		Press-on lens, Fresnell prism, per lens	B.R.
P	V2730		Special base curve, glass or plastic, per lens	B.R.
	V2740		Tint, plastic, rose 1 or 2, per lens NOTE: Per pair	3.50
	V2741		Tint, plastic, other than rose 1-2, per lens NOTE: Grey or Brown 10%-20% only, per pair	3.50
	V2742		Tint, glass rose 1 or 2, per lens NOTE: Per pair	3.50
P	V2743		Tint, glass other than rose 1 or 2, per lens	B.R.
	V2755		U.V.—Lens NOTE: Per Pair	10.00
	V2770		Occluder lens, per lens	10.00
	V2785		Processing, preserving and transporting corneal tissue	500.00
P	V2799		Vision service, miscellaneous	B.R.
P	Y5200		Vision training devices	B.R.
	Y5201		Polycarbonate lens NOTE: Per pair	20.00

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

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CN-4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625-0049

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual

Refugee Resettlement Program: Eligibility limitations

Proposed Amendments: N.J.A.C. 10:81-10.7 and 10.8

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 44:10-3; 45 CFR 400 and 400.202.

Proposal Number: PRN 1993-464.

Submit comments by October 7, 1993 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments reduce the duration of the assistance period through the State administered refugee cash assistance (RCA) and refugee medical assistance (RMA) programs for Aid to Families with Dependent Children -N segment (AFDC-N) and General Assistance (GA) type refugee recipients, who are not eligible for the Federal categorical assistance programs (AFDC and Supplemental Security Income). The period is reduced from a refugee's first 12 months in the United States (from date of entry) to a refugee's first eight months in the United States. This reduction is necessitated by the limited Federal funds appropriated for transitional cash assistance (that is, RCA) and medical services (TAMS) for such individuals. Refugee assistance under Section 412 of the Immigration and Nationality Act (INA) is expressly limited by the extent of available Federal appropriations (8 U.S.C. 1522(a)(1)(A) and 45 CFR 400.202). Each year, the Federal Department of Health and Human Services (USDHHS) reviews the numbers of refugees who enter the country in the prior year, as compared to the refugee admissions ceiling for that Federal fiscal year established by the President after consultation with Congress, pursuant to sections 207 and 101(a)(42) of the INA, and any fixed Federal appropriations available to cover the costs of TAMS. Based on that analysis and historical data, the length of time of coverage for these services is determined to ensure that the resources are available for newly arriving refugees in any given fiscal year.

Since this time-limited eligibility for RCA/RMA is adjusted periodically by the Federal government based on the aforementioned analysis and on Congressional funding limitations, and since the Department would not be able to propose and adopt such changes within the prescribed Federal time-frames without adversely impacting the public interest, future modifidations of the eligibility period will be presented by the Department through a Public Notice in the New Jersey Register. Pursuant to 45 CFR 400.202, the Federal Office of Refugee Resettlement will notify the State of the intent to modify the refugee assistance period based on the availability of Federal funds and will periodically publish updates in the Federal Register. Although the eligibility periods had previously been annual publications in the Federal Register, most recently two adjustments occurred within the year, giving the State reason to make this change in practice in utilizing public notice to communicate any updates, rather than going through the administrative rulemaking process.

N.J.A.C. 10:81-10.7(b) is amended to reduce the eligibility period for AFDC-N and GA-type refugees for refugee cash and medical assistance, from 12 months to eight months from the date of entry into the United States. Additionally, language has been added to reflect a change in practice for future revisions to the eligibility duration for RCA and RMA. Based on the fact that the eligibility periods are controlled by Federal appropriations and refugee data, the proposed amendments modify the current methodology of how the State notifies the public of changes to the RCA/RMA eligibility. Subsequent changes will be announced by a public notice published in the New Jersey Register by the Department, as needed, and reflected in the rule. A stylistic change has been made to delete the citation for Schedule I, replacing it with the word "the", since the paragraph already refers to GA and AFDC-N applicants/recipients, and it is not necessary to include the citation for GA and AFDC-N eligibility. N.J.A.C. 10:81-10.8(a)5 has been amended to reduce the eligibility period for refugees under RMA from two years to eight months from date of entry into the United States. A cross-reference to the previously detailed public notice process is also added to clarify the procedure for notification of any subsequent updates.

Social Impact

The proposed amendments will negatively impact the Federal funding to the State and its counties for individuals covered by the terms of these refugee assistance programs.

The USDHHS considers it of the utmost importance to provide refugee support in a manner that ensures the availability of Federal refugee support throughout the year. Failure on the part of USDHHS to decrease the months of eligibility would mean that Federal funds appropriated would be insufficient to carry the RCA and RMA programs through the current fiscal year. As such, the State must reduce the duration of RCA and RMA from a refugee's first 12 months in the United States to a refugee's first eight months in this country to follow the Federal changes.

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Under current Federal statutes and regulations, the duration of benefits is a function of the level of appropriations. Therefore, Congressional funding limitations establish the eligibility period for RCA and RMA. Due to this fact, the Department believes that future updates through the normal rulemaking process are rendered unnecessary, since the State cannot change the Federal appropriations process, the determining factor for the RMA and RCA programs. Additionally, insufficient time is permitted for the State to follow its normal process to amend the rule. As such, the State practice in notifying the public of changes in the RCA/RMA program eligibility period will be changed. The State will use the public notice process via the New Jersey Register for any subsequent changes.

Economic Impact

Due to the Federal appropriation of funds for the Refugee Resettlement Program, the eligibility period has been reduced from 12 months to eight months. This will result in the loss of Federal revenue at an estimated rate of $183,000 annually. The estimated rate of reduction is 20 percent for AFDC-N and GA type refugees as a result of the change from 12 months to eight months. Approximately 65 cases on the refugee caseload will be impacted by these proposed amendments.

Regulatory Flexibility Statement

The proposed amendments have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments impose no reporting, recordkeeping or other compliance requirements on small businesses; therefore, a regulatory flexibility analysis is not required. The rules govern a program designed to certify eligibility for public assistance to a low-income population by a governmental agency rather than a private business establishment.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:81-10.7 Eligibility

(a) (No change.)

(b) Eligibility limitations: Eligibility for assistance under RRP is limited to a total of [12] **eight** months for AFDC-N and General Assistance type cases, and four months for AFDC-C and -F type cases. **Pursuant to Sections 207 and 101(a)(42) and 1522(a)(1)(A) of the Immigration and Nationality Act (8 U.S.C.) and 45 CFR 400.202, refugee assistance (both RCA/RMA) is limited by the extent of available Federal appropriations in any Federal fiscal year (FFY), and on data concerning refugee arrivals, eligibility and participation in RCA/RMA. Therefore, the State administered RCA/RMA program period of eligibility is dependent on the fixed Federal appropriation made available to the states for any given FFY, based on the aforementioned criteria. Eligibility periods for RCA and RMA are published periodically in the Federal Register. Subsequent updates to these eligibility periods in the Federal Register will be published as a public notice by the Department in the New Jersey Register, and this subsection revised accordingly as an administrative change.**

1. (No change.)

2. Rules concerning GA (AFDC-N or GA) type cases are as follows:

i. For all GA and AFDC-N type applicants/recipients residing in the U.S. for [12] **eight** months or less from their initial entry date or when parole status was first granted as identified on INS Form I-94, income and resources shall be treated in accordance with the standards and criteria applicable to AFDC-C or -F, except, that CWA's shall not apply the $30.00 and one-third earned income disregard. The assistance standard for applicants/recipients shall be the appropriate amount for **the** eligible family since [using Schedule I found in N.J.A.C. 10:81-1.2].

ii. During the [12] **eight** month period, all eligible GA type cases will retain Medicaid eligibility.

(c)-(j) (No change.)

10:81-10.8 Medical assistance and medical expense spend-down

(a) Medical assistance: State eligibility standards for Title XIX shall apply to a refugee's eligibility for medical assistance except:

1.-4. (No change.)

5. All refugees who have been in the U.S. for [two years] **eight months** will no longer be eligible for medical or cash assistance under RRP. **Any subsequent update to this eligibility period for medical or cash assistance under RRP will be published as public notice by the Department in the New Jersey Register (see N.J.A.C. 10:81-10.7(b)), and this paragaraph revised accordingly as an administrative change.**

(b) (No change.)

CORRECTIONS

(a)

THE COMMISSIONER

Blood Donation by Inmates
Autologous Blood Donation
Proposed Amendment: N.J.A.C. 10A:16-9.1

Authorized By: William H. Fauver, Commissioner, Department of Corrections.

Authority: N.J.S.A. 30:1B-6, 30:1B-10 and 26:2A-13 et seq.

Proposal Number: PRN 1993-467.

Submit comments by October 7, 1993 to:
William H. Fauver, Commissioner
Department of Corrections
CN 863
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Currently, the donation of blood by inmates is prohibited with no exceptions. Pursuant to the Blood Safety Act of 1991 (N.J.S.A. 26:2A-13 et seq.), the language at N.J.A.C. 10A:16-9.1 will be amended to allow inmates to donate blood for their own exclusive use (an autologous donation) before an anticipated non-emergency, scheduled surgical procedure. The donation of blood by an inmate intended for use by someone other than that donor inmate (a homologous donation) will remain prohibited with no exceptions.

Social Impact

Human blood and blood components are used as a frequent and necessary therapeutic procedure in medical practice. Since blood is a biological fluid, the improper transfusion of this substance can lead to the spread of diseases such as AIDS and viral heptatis. Many surgeries do not require blood transfusions; however, when a blood transfusion is required this proposed amendment will permit inmates to have the option of donating their own blood (autologous) for use during and/or after their non-emergency, scheduled surgical procedure. Permitting inmates to use their own blood during and/or after surgery should spare the inmate from, and decrease the risk of, allergic reactions and/or the transmission of transfusion-related diseases. The reinfusion of autologous blood collected from an inmate should reassure that inmate's confidence in the blood supply. Additionally, autologous inmate blood transfusions decrease the demand for blood from the volunteer blood donor community. A negative social reaction to this amendment is not anticipated.

Economic Impact

Although it is difficult to gauge the full economic impact of this proposed amendment, it is probable that a decreased risk of allergic reactions and the transmission of transfusion-related diseases (such as AIDS or viral hepatitis) will result. The use of autologous blood transfusions will minimize the probable medical costs associated with the treatment of the diseases or reactions that could occur with a homologous blood transfusion. The choice of an inmate to donate and have his or her own blood reinfused during and/or after a surgical procedure will result in a decrease in blood demand and the costs associated with homologous donor blood replacement at blood banks. Additional State financial resources will not be necessary to implement or maintain this amendment.

Regulatory Flexibility Statement

The proposed amendments have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments will have an infinitesimal impact on those blood banks that are considered small businesses as defined under the Regulatory Flexibility Act, in that homologous blood replacement will not be necessary when an inmate chooses to utilize an autologous transfusion. The amend-

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ments do not impose reporting, recordkeeping or other compliance requirements on small businesses; therefore, a regulatory flexibility analysis is not required. The proposed amendment impacts on the health of inmates and the New Jersey Department of Corrections.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10A:16-9.1 Blood donation

(a) In accordance with the Blood Safety Act of 1991 (N.J.S.A. 26:2A-13 et seq.), the [Donation] **donation** of blood by inmates **to other individuals (homologous)** is prohibited. There shall be no exceptions to this prohibition.

(b) When medically necessary or appropriate, the donation of blood by an inmate for his or her exclusive use (autologous) in anticipated non-emergency, scheduled surgery will be permitted.

INSURANCE

(a)

DIVISION OF ENFORCEMENT AND CONSUMER PROTECTION

Unfair Claims Settlement Practices
Written Notice by Insurers of Payment of Third-Party Claims

Reproposed New Rule: N.J.A.C. 11:2-17.11

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:29B-1 et seq. and 17B:30-1 et seq.

Proposal Number: PRN 1993-468.

Submit comments by October 7, 1993 to:
Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625

The agency proposal follows:

Summary

This reproposed new rule requires insurers, at the same time payment of a third-party claim is being made, to provide written notice of payment to the claimant. The purpose of this amendment is to ensure that third-party claimants are made aware that payment of their claim has been made in order to deter those rare instances where the client's attorney or other representative would attempt to misappropriate these funds.

This reproposed rule stems from a decision of the New Jersey Supreme Court striking down Opinion 635 of the Advisory Committee on Professional Ethics (ACPE) approving the use by attorneys of an Authorization to Endorse form. (See *In the Matter of Advisory Committee on Professional Ethics Opinion 635,* Dkt. No. A-118/119, decided July 25, 1991.) Such a form would permit attorneys to endorse settlement checks on behalf of their clients only after a settlement had been consummated, the release had been executed, and the client had signed the required closing statement. It was the court's opinion that such a procedure should be used only in certain extraordinary circumstances because the advantage gained in client convenience by using the form was outweighed by the risk of unscrupulous lawyers victimizing their clients.

Nevertheless, the court pointed out that the risks implicit in the use of such a procedure would be substantially reduced if a regulation were in place requiring the clients to be notified by their insurers when and for what amount a check had been issued. The court made reference to the success of such a regulation in effect in New York since 1988. Accordingly, this reproposed rule addresses the court's concern that unscrupulous attorneys could successfully misrepresent to their clients whether and for what amount a check had been issued by an insurer in payment of a third-party claim.

New York's regulation (N.Y. Comp. Codes R. & Regs., tit. xi, §216.9 (1988)) requires insurers to notify third-party claimants when and in what amount any check of $5,000 or more in payment of the claim has been issued to the claimant's attorney or other representative. The New York regulation further states that only the Insurance Department may initiate a cause of action against an insurer who violates the regulation, and that the regulation is not intended to establish a defense for any party to any cause of action resulting from a violation of the regulation.

On February 18, 1992, the Department proposed a new rule (see 24 N.J.R. 522(a)) based on the New York regulation. The rule then proposed required an insurer to mail written notice to a third-party claimant when payment of the claim is made to the claimant's attorney or other representative. Unlike New York's regulation, however, the proposed rule required that the insurer notify the claimant in all cases where the settlement check is $1,000 or more. During the comment period ending March 19, 1992, the Department received a total of three timely comments from Selective Insurance, Prudential Insurance and the Market Transition Facility of New Jersey (MTF) on the rule as originally proposed, which are summarized as follows:

COMMENT: All three commenters made reference to the economic impact of the proposed new rule on insurers. Two commenters stated that the rule is not cost effective considering both the minimal number of incidents where unscrupulous lawyers would victimize their clients and the burden placed on insurers to comply with the rule's notice requirements. One commenter suggested that the rule apply only to claims of at least $20,000, while another stated that only bodily injury claims of at least $5,000 should trigger the rule's notice requirement.

RESPONSE: While the Department recognizes that these reproposed rules impose new costs on insurers which are not directly offset by savings to those same insurers, the Department cannot agree with the comment that the rule's notice requirement is not cost effective to the tort reparations system as a whole. The rule's requirement that insurers send an additional notice of payment directly to third-party claimants at the same time payment of their claims is sent to their attorneys or other representatives cannot be characterized as overly burdensome to insurers since the cost involved is negligible. On the other hand, the benefits resulting from the rule's notice requirement are significant. This rule would deter attorney misappropriation of client funds, as well as reduce costs to the Lawyers Client Security Fund. Even if the actual number of occurrences of misappropriation of client funds in the manner described in this rule is currently small, this rule could effectively eliminate those instances.

The Department has reconsidered its position concerning the amount of claims to which the rule is applicable. As the Department stated in its original proposal, the loss of any amount of third-party claim funds to an unscrupulous attorney's misappropriation is devastating to the claimant himself. Nevertheless, the economic burden placed on insurers to comply with this rule's requirement may be lessened if the notices required to be sent applied only to claims of at least $5,000, rather than $1,000 as originally proposed by the Department. Furthermore, restricting the notice requirement to claims of at least $5,000 will allow for consistency with New York's regulation, thereby enabling insurers transacting business in both states to have the same requirement concerning third-party claims notices.

COMMENT: One commenter stated that the proposed new rule is unnecessary because a client whose attorney has misappropriated his or her client's funds already has three avenues of recovery: reimbursement from the Lawyers Fund for Client Protection, a civil action agianst the attorney for conversion of funds, and client initiated disciplinary action against the attorney through the State Disciplinary Review Board.

RESPONSE: The three methods of obtaining relief suggested by the commenter would only apply after an attorney succeeded in misappropriating his or her client's funds. Moreover, all of these avenues would require the already-victimized client to bear the additional burden of initiating these proceedings and waiting indefinitely for their conclusion, while still not receiving any guarantee of reimbursement. The Department reiterates that the purpose of this rule is to protect the public and obviate the necessity for third-party claimants to become involved in any of these suggested avenues of recovery by deterring at the outset the potential for attorneys to misappropriate funds belonging to their third-party claimant clients.

COMMENT: One commenter states that the proposed rule will not prevent attorney misconduct, and will further address only those instances of attorney misappropriation of client funds involving insurance claims.

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RESPONSE: The Department does not intend this rule to be a panacea for attorney misconduct generally or even for attorney misappropriation of funds. However, the Department does believe that this rule will likely deter the specific type of misconduct addressed by the rule.

COMMENT: One commenter stated that the legal profession itself is capable of policing its members, and that it can alter its enforcement mechanisms if they are not totally successful.

RESPONSE: The Department does not entirely disagree with the commenter's statement. However, the commenter's statement is beyond the scope of this proposed rule.

COMMENT: One commenter stated that the notice requirement of this proposed rule constitutes an unnecessary interference with the attorney-client relationship.

RESPONSE: The Department reiterates its position that, contrary to the commenter's statement, this proposed rule is intended to protect a third-party claimant from an attorney's misappropriation of client funds before the fact at minimal cost or burden to those insurers required to comply with the rule's requirements.

Pursuant to N.J.A.C. 1:30-4.2(c), a proposal must be adopted and filed with the Office of Administrative Law within one year of publication in the New Jersey Register. The expiration date for the adoption of this rule as originally proposed was February 18, 1993. The Department now reproposes this rule requiring that insurers provide written notice to the claimants of payment of third-party claims in the amount of at least $5,000.

Social Impact

This reproposed rule will have a favorable social impact on third-party claimants affected by the rule insofar as the rule will deter those rare instances where an attorney would attempt to misappropriate a client's third-party claim settlement check. It is less likely that an attorney would attempt to mislead a client concerning a claim settlement check when the attorney is fully aware that the client was notified by the insurer of payment of the claim.

Economic Impact

The reproposed rule will have a minimal economic impact on those insurers making payment on third-party liability claims insofar as they will be required to mail written notice of payment to the third-party claimant. This requirement may cause the insurers to incur additional expenses in actually preparing the notices and the mailing costs. However, these costs would be minimal. Moreover, these costs are far outweighed by the benefits the public will obtain (that is, a strong deterrent against the possible misappropriation of client funds).

The proposed rule will have no economic impact on the Department.

Regulatory Flexibility Analysis

The reproposed rule will affect certain insurers that are small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., in that the rule requires all insurers making payment on third-party liability claims to mail written notice of payment to the third-party claimant. However, the cost of preparing and mailing such notice would be minimal. The rule requires only that very fundamental information be conveyed to third-party claimants in the notice, demanding that no additional significant amount of time be spent by the insurer's staff. No professional services are required. Additionally, the insurer would only incur regular mail costs to send the notices. Therefore, no lesser requirements or exemptions are provided based on business size.

Full text of the reproposed new rule follows:

11:2-17.11 Written notice by insurers of payment of third-party claims

(a) Upon payment of $5,000 or more in settlement of any third-party liability claim, where the claimant is a natural person, the insurer or its representative (including the insurer's attorney) shall mail to the third-party claimant written notice of payment at the same time payment is made to the third-party claimant's attorney or other representative.

(b) The written notice referred to in (a) above shall be mailed to the claimant by regular mail at the claimant's last known address, and shall include at least the following information:

1. The amount of the payment;
2. The party or parties to whom the check is made payable;
3. The party to whom the check was mailed; and
4. The address of the party to whom the check was mailed.

(c) Nothing in (a) above shall create, or be construed to create, a cause of action for any person or entity, other than the Department of Insurance, against the insurer or its representative based upon a failure to serve such notice, or the defective service of such notice. Nothing in (a) above shall establish, or be construed to establish, a defense for any party to any cause of action based upon a failure by the insurer or its representative to serve such notice, or the defective service of such notice.

Recodify existing N.J.A.C. 11:2-17.11 through 17.14 as **17.12 through 17.15** (No change in text.)

LABOR

(a)

DIVISION OF PROGRAMS

1994 Maximum Weekly Benefit Rates
1994 Taxable Wage Base Under the Unemployment Compensation Law
1994 Contribution Rate of Governmental Entities and Instrumentalities
1994 Base Week
1994 Alternative Earnings Test
Proposed Amendments: N.J.A.C. 12:15-1.3. 1.4, 1.5, 1.6 and 1.7

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e), 43:21-3(c), 43:21-4(e), 43:21-7(b)(3), 43:21-7.3(e), 43:21-19(t), 43:21-27, 43:21-40 and 43:21-41.

Proposal Number: PRN 1993-486.

Submit written comments by October 7, 1993 to:
Linda Flores, Special Assistant
External and Regulatory Affairs
Office of the Commissioner
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

The proposed amendment to N.J.A.C. 12:15-1.3 establishes the 1994 maximum weekly benefit rate for benefits under the Unemployment Compensation Law and for State Plan benefits under the Temporary Disability Benefits Law.

The proposed amendment to N.J.A.C. 12:15-1.4 establishes the 1994 taxable wage base for the purpose of contributions under the Unemployment Compensation Law in accordance with N.J.S.A. 43:21-7(b)(3).

The proposed amendment to N.J.A.C. 12:15-1.5 establishes the 1994 contribution rate for governmental entities that elect to pay contributions under the Unemployment Compensation Law.

The proposed amendment to N.J.A.C. 12:15-1.6 raises the amount of earnings required in 1994 to establish a base week for an individual's claim for unemployment compensation and State Plan temporary disability benefits.

Finally, the proposed amendment to N.J.A.C. 12:15-1.7 raises the amount of base year earnings required to establish an individual's eligibility for unemployment compensation and State Plan temporary disability benefits in those instances in which the individual has not established 20 base weeks.

Social Impact

The proposed amendment to N.J.A.C. 12:15-1.3 will ensure that payments to unemployment and disability insurance recipients entitled to maximum benefits will increase in line with the upward trend of wages in the State's economy, thus preserving the real purchasing power of their benefits.

The proposed amendment to N.J.A.C. 12:15-1.4 will generate increased revenues for the Unemployment Insurance and Disability In-

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surance Trust Funds needed to offset the increased level of benefits for these programs, which are statutorily indexed to the upward trend of wages in the State's economy.

The proposed amendment to N.J.A.C. 12:15-1.5 will maintain the contribution rate for governmental entities that elect to pay contributions under the Unemployment Compensation Law and will have no social impact on the public.

The proposed amendments to N.J.A.C. 12:15-1.6 and 12:15-1.7 provide for the base week amount and the amount of earnings to establish eligibility, respectively, to be indexed to wage increases as benefit payments have been indexed since 1969. Some claimants who work temporarily or intermittently may not qualify for benefits under these eligibility standards.

Economic Impact

The proposed amendments to N.J.A.C. 12:15-1.3 will increase the weekly benefit rates received by individuals eligible for the maximum weekly benefit rate under the Unemployment Compensation Law and under the Temporary Disability Benefits law beginning January 1, 1994, in compliance with statutory provisions which automatically adjust these benefit rates each year in accordance with changes in the Statewide average weekly wage. The maximum weekly benefit for the Unemployment Compensation is computed as 56⅔ percent of the Statewide average weekly wage in the second preceding calendar year. As of January 1, 1994, the maximum weekly benefit will increase from $325.00 to $347.00.

The maximum weekly benefit for State Plan Temporary Disability is computed as 53 percent of the Statewide average weekly wage in the second preceding calendar year. As of January 1, 1994, the maximum weekly benefit will increase from $304.00 to $325.00.

The proposed amendment to N.J.A.C. 12:15-1.4 will increase, from $16,100 to $17,200, the wages of an individual employee of an employer that are subject to employer and worker contributions under the Unemployment Compensation Law, beginning January 1, 1994. The taxable wage base is computed as 28 times the Statewide average weekly wage in the second preceding calendar year.

The proposed amendment to N.J.A.C. 12:15-1.5, which will maintain the contribution rate for governmental entities at 0.4 percent of taxable wages for 1994, will result in no increase in costs to State and local government units that choose this financing option, provided that all other factors that might influence the level of contributions remain the same.

The proposed amendment to N.J.A.C. 12:15-1.6 will increase the amount an individual must earn to establish a base week under the Unemployment Compensation and Temporary Disability Benefits Laws. The amount is computed as 20 percent of the Statewide average weekly wage in the second preceding calendar year and will increase from $115.00 to $123.00 for benefit years and periods of disability commencing January 1, 1994.

The proposed amendment to N.J.A.C. 12:15-1.7 increases the alternative earnings eligibility standard under the law in those situations where the individual has not established 20 base weeks in the base year period. The amount will increase from $6,900 to $7,400 in 1994. The alternative earnings test is indexed each year at 12 times the Statewide average weekly wage in the second preceding calendar year.

The Department does not expect to experience any economic impact as a result of the proposed amendments.

Regulatory Flexibility Statement

The proposed amendments do not impose any reporting, recordkeeping or compliance requirements on small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments affect benefit and contribution levels under the Unemployment Compensation and Temporary Disability Benefits Laws. Thus, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

12:15-1.3 Maximum weekly benefit rates

(a) In accordance with the provisions of the Unemployment Compensation Law, the maximum weekly benefit rate for benefits under the Unemployment Compensation Law is hereby promulgated as being [$325.00] **$347.00** per week.

(b) The maximum weekly benefit rate for State Plan benefits under the Temporary Disability Benefits Law is hereby promulgated as being [$304.00] **$325.00** per week.

(c) These maximum benefits shall be effective for the calendar year [1993] **1994** on benefit years and periods of disability commencing on or after January 1, [1993] **1994**.

12:15-1.4 Taxable wage base under the Unemployment Compensation Law

In accordance with the provisions of N.J.S.A. 43:21-7(b)(3), the "wages" of any individual with respect to any one employer for the purpose of contributions under the Unemployment Compensation Law shall include the first [$16,100] **$17,200** during the calendar year [1993] **1994**.

12:15-1.5 Contribution rate for governmental entities and instrumentalities

(a) In accordance with the provisions of N.J.S.A. 43:21-7.3(e), the contribution rate for all governmental entities and instrumentalities electing to pay contributions under the Unemployment Compensation Law is hereby promulgated as being four-tenths of one percent (0.4 percent) for the entire calendar year.

(b) This contribution rate shall be effective on taxable wages paid in the calendar year [1993] **1994**.

12:15-1.6 Base week

In accordance with the provisions of N.J.S.A. 43:21-19(t), the base week amount is hereby promulgated as being [$115.00] **$123.00** per week for benefit years and periods of disability commencing on or after January 1, [1993] **1994**.

12:15-1.7 Alternative earnings test

In accordance with the provisions of N.J.S.A. 43:21-4(e) and 43:21-41, in those instances in which the individual has not established 20 base weeks, the alternative earning amount for establishing eligibility is hereby promulgated as being [$6,900] **$7,400** for benefit years and periods of disability commencing on or after January 1, [1993] **1994**.

(a)

DIVISION OF PROGRAMS

Offset of Unemployment Insurance Benefits by Retirement and Pension Income

Proposed Amendment: N.J.A.C. 12:17-11.2

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

Authority: N.J.S.A. 43:21-1 et seq.; specifically 43:21-5a.

Proposal Number: PRN 1993-487.

Submit written comments by October 7, 1993 to:
Linda Flores, Special Assistant
External and Regulatory Affairs
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

The Unemployment Insurance Law, N.J.S.A. 43:21-1 et seq., was enacted for the dual purpose of guarding against the hazards of involuntary unemployment and encouraging employers to provide more stable employment. The Unemployment Insurance Law accomplishes this purpose by compelling the systematic accumulation of funds during periods of employment, thus maintaining purchasing power and limiting the serious social consequences of involuntary unemployment. Benefits are available to unemployed workers who meet qualifying and eligibility requirements.

In 1980 Congress enacted legislation which required the states to reduce the payment of unemployment benefits by the amount individuals receive for a variety of pension payments, taking into account the amount individuals contribute. To conform to Federal law, the New Jersey

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Legislature amended the State's unemployment law to require unemployment benefits to be reduced by retirement income, N.J.S.A. 43:21-5a. Although N.J.S.A. 43:21-5a speaks in broad terms, it authorizes the Commissioner to prescribe by regulation the specific manner in which unemployment insurance benefits are to be reduced by retirement income.

N.J.A.C. 12:17-11 establishes the rules governing the offset of unemployment insurance benefits by retirement and pension income. N.J.A.C. 12:17-11.2 specifically provides that if an individual contributes any amount to his or her pension, including social security, the unemployment insurance benefits are reduced by 50 percent of the pension amount; if no contribution is made by an individual, the unemployment insurance benefits are reduced by 100 percent; and, if the individual finances 100 percent of the cost of the pension, no reduction is made. The Department proposes to amend N.J.A.C. 12:17-11.2 by exempting recipients of social security pensions from the 50 percent pension reduction in unemployment benefits. As a result of this change, benefit reductions due to the receipt of a social security pension would be eliminated.

Social and economic factors support the proposed amendment. The wave of plant closings and corporate downsizings that has occurred recently has forced many workers to "retire" earlier than they had anticipated. To the extent these individuals may be receiving social security pensions, they are nonetheless still very much attached to the labor market. Moreover, to an increasing extent in recent years, Federal rules governing the amount of wages that can be earned without reducing social security benefits have been liberalized. No longer requiring unemployment insurance benefits to be reduced due to the receipt of social security benefits would be consistent with this trend. In addition, the Department has over the years received a substantial number of constituent complaints through State and Federal legislators regarding the State's pension offset rule. Other states, including New York, do not reduce the unemployment insurance benefits of social security recipients. The proposed amendment would eliminate this source of additional frustration from the public, particularly those who commute from or live adjacent to New York.

The Employment Security Council has also considered this issue. The Employment Security Council, whose members are appointed by the Governor with the advice and consent of the Senate, consists of representatives of employers, employees and the general public. The Council reviews the New Jersey Unemployment and Temporary Disability Insurance programs and provides advice to the Governor, Legislature and the Commissioner of Labor regarding these and related programs.

At its bimonthly meeting on June 28, 1993, the Employment Security Council unanimously resolved to endorse the elimination of the reduction of unemployment insurance benefits by social security pension benefits. The Council reasoned that social security benefits are payable as a result of life-long employment and, thus, are not attributable solely to the claimant's last employer. In addition, the Council was mindful that the proposed amendment of the pension rules would substantially assist the poorest segment of the population. Finally, the Council determined that the recommended action would have a minimal impact on the Unemployment Insurance Trust Fund. For these reasons, the Council urged the Commissioner to adopt a regulatory amendment which would eliminate the offset of unemployment insurance benefits by social security income.

For these reasons and in light of the Employment Security Council's unanimous support, the Department proposes the elimination of the reduction of unemployment insurance benefits by the social security pension.

Social Impact

The proposed amendment would have a positive social impact on older workers and individuals who receive social security pensions because they would be eligible to collect the full amount of the unemployment insurance benefits when they become involuntarily unemployed. By allowing older workers to receive full unemployment benefits without the social security offset, the proposed amendment will have a salutary effect on the economic well-being of older workers who are often at the bottom end on the economic ladder. This, in turn, would further their economic independence and provide a much needed social safety net for older workers.

The proposed amendment would also be consistent with the recent trend at the Federal level to liberalize the amount of outside income allowed without reducing social security benefits. The proposed action would also eliminate constituent complaints and frustrations regarding the State's pension offset rule and bring the State in line with other states.

Finally, once the current economic expansion gets fully underway, it is expected that the labor shortages experienced during the 1980s could well reemerge. With an increasing proportion of the labor force expected to be comprised of individuals over 60 years old, elimination of the deductibility of social security income may serve as an incentive for those in this age group to remain in the labor force, thereby benefitting the business community and the state as a whole.

Economic Impact

The amount of the social security award is based upon older retired workers' pre-retirement full-time employment. Because the size of the social security award is substantial relative to the amount of the unemployment benefits, the amount of unemployment benefits they are eligible to receive is often reduced to zero or a minimal amount. This proposed amendment would eliminate the reduction in unemployment benefits based upon social security pension benefits. Under the proposed amendment, older retired workers who are supplementing their social security benefits would be eligible for unemployment benefits without reduction should they become involuntarily unemployed.

While no precise price tag can be attached to this proposed change, data suggest that the cost to the Unemployment Insurance Trust Fund would be approximately 1.1 percent of benefit payments. Thus, although the Unemployment Insurance Trust Fund will be impacted, the impact is expected to be minimal and readily absorbable by the Fund.

Finally, the amendment will result in increased benefit charges against employers' experience rating accounts. This increase is minimal and is outweighed by the positive social and economic benefits which will be realized by older retired workers. The State's economy will also benefit by maintaining older workers' purchasing power.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendment does not impose reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. In fact, the proposed amendment imposes no compliance requirements upon any employer. Any reporting, recordkeeping or other compliance requirements are assumed entirely by the Department of Labor which performs the necessary calculations and provides the tax bill to each employer based upon his or her unemployment experience. Accordingly, a regulatory flexibility analysis is not required.

Full text of the proposed amendment follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

12:17-11.2 Amount of reduction

(a) For weeks of unemployment beginning on or after January 1, 1981, the amount of any such reduction shall be determined by taking into account contributions made by the individual for the pension, retirement or retired pay, annuity and other similar periodic payment. The following schedule will apply.

1.-2. (No change.)

3. No reduction in benefits shall be made if the pension, retirement or retired pay, annuity or other similar periodic payment received by the individual is from an Old Age Social Security pension to which the individual has made any contribution.

[3.]**4.** (No change in text.)

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(a)

DIVISION OF WORKERS' COMPENSATION

1994 Maximum Workers' Compensation Benefit Rates

Proposed Amendment: N.J.A.C. 12:235-1.6

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e) and 34:15-12a.

Proposal Number: PRN 1993-488.

Submit written comments by October 7, 1993 to:
Linda Flores, Special Assistant
External and Regulatory Affairs
Office of the Commissioner
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

The proposed amendment establishes the 1994 maximum workers' compensation benefit rates for temporary disability, permanent total disability, permanent partial disability and dependency.

Social Impact

The proposed amendment will ensure that payments to workers' compensation recipients entitled to maximum benefits will increase in line with the upward trend of wages in the State's economy, thus preserving the real purchasing power of their benefits.

Economic Impact

The proposed amendment will increase from $431.00 to $460.00 the weekly benefit rate received by individuals eligible for the maximum weekly benefit rate for temporary disability, permanent total disability, permanent partial disability and dependency under the Workers' Compensation Law.

The effect of this change will be to raise the employer's workers' compensation insurance costs, provided that all other factors that might influence workers' compensation insurance costs remain the same.

The Department does not expect to experience any economic impact as a result of the proposed amendment.

Regulatory Flexibility Statement

The proposed amendment does not impose any reporting, recordkeeping or compliance requirements on small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendment increases benefit rates to individuals. Thus, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

12:235-1.6 Maximum workers' compensation benefit rates

(a) In accordance with the provisions of N.J.S.A. 34:15-12(a), the maximum workers' compensation benefit rate for temporary disability, permanent total disability, permanent partial disability, and dependency is hereby promulgated as being [$431.00] **$460.00** per week.

(b) This maximum compensation shall be effective as to injuries occurring in the calendar year [1993] **1994**.

LAW AND PUBLIC SAFETY

(b)

DIVISION OF MOTOR VEHICLES

Executive and Administrative Service Insurance Verification

Proposed Amendments: N.J.A.C. 13:18-6.1 and 6.2

Authorized By: Stratton C. Lee, Jr., Director, Division of Motor Vehicles, after consultation with Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:33B-41, 39:3-4e and 39:6B-1 et seq.

Proposal Number: PRN 1993-476.

Submit written comments by October 7, 1993 to:
Stratton C. Lee, Jr., Director
Division of Motor Vehicles
Attention: Legal Services Office
225 East State Street
CN 162
Trenton, New Jersey 08666

The agency proposal follows:

Summary

The insurance verification rules adopted by the Division of Motor Vehicles presently require that certain insurers provide the Director with information relating to the cancellation and issuance of private passenger automobile insurance policies. The present rules require reports only from those insurers that issue private passenger automobile insurance coverage on personal lines policies. When the insurance verification program was initiated in 1991, the Director, in consultation with the Commissioner of Insurance, determined to limit the program to personal lines policies at the outset in order to monitor, control and provide proper administration. Initially limiting the program to personal lines insurers was appropriate since this group provided coverage for the great majority of private passenger automobiles. In doing so, however, the Director recognized that obtaining similar information regarding private passenger automobiles insured on commercial lines policies would improve the accuracy of the program, and intended to expand it to include commercial lines insurers in the future. Now that the insurance verification program is operating satisfactorily with information from personal lines insurers, it is appropriate to add information from commercial lines insurers to the system.

The term "personal private passenger automobile insurance" is defined in N.J.A.C. 13:18-6.1 to mean "direct insurance on private passenger automobiles as defined in N.J.S.A. 39:6A-2 issued pursuant to a personal lines rating system filed and approved in accordance with N.J.S.A. 17:29A-1 et seq. . . ." This definition does not encompass private passenger automobiles which are insured under commercial lines policies. The proposed amendment deletes the definition of "personal private passenger automobile insurance" and provides definitions for "private passenger automobile insurance," "personal lines insurer" and "commercial lines insurer." N.J.A.C. 13:18-6.2 is also amended as necessary to extend the insurance verification program to commercial lines insurers.

The proposed amendments are intended to further implement section 50 of the Fair Automobile Insurance Reform Act of 1990, N.J.S.A. 17:33B-41, by extending the administrative insurance verification program, which is designed to enhance public compliance with the State's compulsory motor vehicle liability insurance laws, to private passenger automobiles that are insured under commercial lines policies. To this end, the proposed amendments will have the effect of requiring commercial lines insurers to provide to the Director information relating to the cancellation and issuance of private passenger automobile insurance policies on a monthly basis beginning on December 7, 1993. The information provided will be policy cancellation and issuance activity occurring on and after October 1, 1993. The proposed amendments will also have the effect of requiring that commercial lines insurers provide to the Director on a semi-annual or request basis information concerning all current private passenger automobile policies issued by them. Furthermore, the amendments will have the effect of requiring that commercial lines insurers develop or modify their existing information systems so that they may provide information relating to the termination

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of automobile insurance policies for reasons other than nonpayment of premium, such as cancellation or nonrenewal, as the Directory may require.

Social Impact

The proposed amendments will have a beneficial social impact. The amendments implement the public policy of this State as expressed by the FAIR Act. One of the primary objectives of the FAIR Act is to ensure that owners of automobiles which are registered or principally garaged in New Jersey maintain automobile liability insurance coverage. To this end, the amendments extend the administrative verification procedure in order to identify those owners whose private passenger automobiles are insured under commercial lines policies which have been cancelled because of nonpayment of premium or those owners who have never had insurance coverage and to institute suspension action against vehicle registrations and driving privileges when an owner fails to provide acceptable proof of insurance or prove the existence of special circumstances which the Director deems sufficient justification to withhold suspension activity.

By obtaining information from commercial lines insurers as well as personal lines insurers, the accuracy of the insurance verification program will be significantly enhanced, and the chance of misidentifying as uninsured a private passenger automobile insured on a commercial lines policy will be substantially reduced. This will provide a beneficial social impact in that individuals properly insured on a commercial lines policy will not be required to provide proof to the Division, or risk suspension of registration and driving privileges if they fail to do so. Similarly, the improved accuracy will properly identify as uninsured those automobiles formerly insured on a commercial lines policy.

It is anticipated that the amendments will assist in reducing the number of uninsured motor vehicles in New Jersey. A reduction in the number of uninsured vehicles should lower the cost of automobile insurance to the general public. The amendments will have no social impact upon the Division of Motor Vehicles.

Economic Impact

The proposed amendments impose an economic impact on the Division of Motor Vehicles in that the DMV is responsible for the implementation and administration of an insurance verification program which satisfies the requirements of N.J.S.A. 17:33B-41. It is estimated that the extension of the insurance verification program as provided by the proposed amendments will result in a total cost to the Division of Motor Vehicles of approximately $23,000 per year. The Division anticipates funding the extended program as provided by law.

Commercial lines insurers required to submit information pursuant to the proposed amendments will incur costs in connection with assimilating, preparing and supplying the required insurance information. These costs will vary greatly from company to company depending on the nature of their existing information systems and the extent of programming changes that are necessitated to comply with these amendments. For this reason, the Division cannot quantify with any degree of certitude the cost that will be incurred by an individual insurance company. To some degree, the added costs of complying with these rules may be offset by reduced complaints to commercial lines insurers and producers from those who are at present identified as potentially uninsured, as well as the more general benefit to all insurers by reducing the number of uninsured vehicles on New Jersey's highways.

Motorists whose driving privileges are suspended by the Division pursuant to N.J.S.A. 17:33B-41 and the insurance verification rules for failure to maintain liability insurance on a motor vehicle are subject to payment of a $30.00 license restoration fee to the Division pursuant to N.J.S.A. 39:3-10a and N.J.A.C. 13:21-9.3

Motorists may seek the rescission of an order of suspension of a vehicle registration or drivers' license pursuant to subsections (d) and (g) of N.J.S.A. 17:33B-41 and N.J.A.C. 13:18-6.8. Such rescission requires, among other things, the payment of a civil penalty in the amount of $4.00 for each day up to 90 days for which motor vehicle liability insurance was not in effect after cancellation for nonpayment of premium. It must be noted that motorists are not obligated to seek such a rescission of suspension, and those choosing not to request such a rescission will not incur the above mentioned cost.

Motorists who have surrendered registration plates to the Division pursuant to N.J.S.A. 17:33B-41 and who thereafter acquire motor vehicle liability insurance coverage and furnish proof of same to the Director will incur a fee in connection with obtaining a valid set of replacement plates for those which had been surrendered. Such motorists will be required to pay a fee of $5.00 to the Division for the set of replacement plates. Such motorists seeking the return of surrendered plates which contain the same combination of letters and numbers as had been contained on the surrendered plates must first pay the $5.00 fee specified above for replacement plates, to be followed by the payment to the Division of a $10.00 fee for the set of special plates.

Regulatory Flexibility Analysis

The proposed amendments will affect commercial lines insurers who qualify as "small businesses" as that term is defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Commercial lines insurers will be required to submit on a monthly basis information relating to the cancellation of insurance policies because of nonpayment of premium and information concerning the issuance of new policies. Additionally, commercial lines insurers will be required to submit semi-annually or on a request basis information relating to all current insurance policies issued by them. Commercial lines insurers may also have to develop or modify existing information systems so as to comply with technical specifications prescribed by the Director.

Approximately 100 insurance companies presently write private passenger automobile insurance on commercial lines policies in this State. The Division of Motor Vehicles estimates that less than five of those companies qualify as "small businesses." The initial capital costs and annual compliance costs to small businesses are limited to those costs incidental to making data and programming changes that are necessary for the commercial lines insurers to provide data in the format prescribed by the Director. These costs will vary greatly depending on the present capability of the information systems maintained by the insurance companies. For this reason, the Division cannot quantify with any degree of certitude the costs that will be incurred by an individual company.

The Division anticipates that the amendments will not require small businesses to engage additional professional services. Virtually every insurance company uses modern data processing techniques in the course of daily business. Furthermore, commercial lines insurers already possess most of the information required to be submitted pursuant to the amendments since such information is necessarily kept as part of the course of business of insuring motor vehicles.

Since one of the statutes which provides authority for the Division of Motor Vehicles' proposed amendments, N.J.S.A. 39:3-4e, empowers the Division to promulgate regulations "requiring insurers to provide all information with respect to the issuance, renewal, cancellation, nonrenewal and termination of insurance as the director may deem necessary to assist the division in enforcement of the provisions of this Title relating to insurance coverage for motor vehicles," and since neither that statute nor the FAIR Act provides for a small business exemption, commercial lines insurers qualifying as small businesses are not exempted from the reporting, compliance and other requirements imposed by the proposed amendments. The Division's purpose in proposing these amendments is to further implement N.J.S.A. 17:33B-41 and to enhance public compliance with this State's compulsory motor vehicle liability insurance laws by extending the insurance verification program which depends upon information submitted by insurance companies on a monthly and semi-annual or request basis as to all private passenger automobiles for which motor vehicle liability insurance has been cancelled, automobiles for which new policies have been issued and automobiles that have policies in effect. The Division would not be able to implement the statutory program if it is not apprised of this information by all insurers, including commercial lines insurers, since it would only have a partial list of uninsured private passenger automobiles and would therefore be unable to determine the universe of private passenger automobiles appearing to be without insurance coverage. Failure to include all insurance companies would create problems of proof for the Division in enforcement proceedings and would inconvenience and potentially jeopardize the registration and driving privileges of motorists who comply with the law by buying insurance from such nonreporting companies. Accordingly, since an exemption of commercial lines insurers which qualify as small businesses from the proposed amendments would defeat the very purpose of the amendments (that is, to enhance public compliance with the State's compulsory motor vehicle liability insurance laws and reduce the cost of auto insurance to the public), a small business exemption from the reporting, compliance and other requirements set forth in the amendments is not consistent with the statutory mandate.

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Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:18-6.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meaning unless the context clearly indicates otherwise.

. . .

"Commercial lines insurer" means a person authorized to transact the business of private passenger automobile insurance in New Jersey pursuant to a commercial lines rating system filed in accordance with N.J.S.A. 17:29A-1 et seq.

. . .

"Insurer" means an entity authorized or admitted to transact the business of [personal] private passenger automobile insurance in New Jersey.

"Newly issued policy" means any contract or endorsement of [personal] private passenger automobile insurance that provides liability coverage for an automobile not previously covered by a contract of liability insurance issued by the insurer, or that was previously covered by a policy issued by the insurer which was cancelled for nonpayment of premium.

"Person" means any natural person or persons, corporation, association, partnership or company authorized by the laws of this State to transact the business of insurance in this State.

"Personal lines insurer" means a person authorized to transact the business of private passenger automobile insurance in New Jersey pursuant to a personal lines rating system filed and approved in accordance with N.J.S.A. 17:29A-1 et seq.

"[Personal private] **Private** passenger automobile insurance" means direct insurance on private passenger automobiles as defined in N.J.S.A. 39:6A-2 [issued pursuant to a personal lines rating system filed and approved in accordance with N.J.S.A. 17:29A-1 et seq.], but excluding [personal] excess liability insurance.

13:18-6.2 Reports of [personal] private passenger automobile insurance policy information to the Director of the Division of Motor Vehicles

(a) Personal [private passenger automobile] **lines** insurers shall provide the Director, or his or her designee, information by vehicle identification number (VIN) concerning the cancellation and issuance of personal private passenger automobile insurance policies on and after February 1, 1991. **Commercial lines insurers shall provide the Director, or his or her designee, information by vehicle identification number (VIN) concerning the cancellation and issuance of private passenger automobile insurance policies on and after October 1, 1993. Commercial lines insurers shall only provide information concerning policies covering private passenger automobiles registered to individual owners.** This information shall be provided on a monthly basis in the manner and form as set forth in Appendices A and B, which are incorporated herein by reference. This information shall be provided in accordance with a schedule of dates set by the Director.

(b) [Insurer] **Personal lines insurers** shall report by magnetic computer tape or cartridge (or, for insurers that write less than 750 personal private passenger automobile insurance policies per year in the State of New Jersey, by magnetic computer tape or cartridge or personal computer diskette) to the Director on a monthly basis beginning September 15, 1991, the following information concerning policies cancelled for nonpayment of premium and newly issued policies. **Commercial lines insurers shall report by magnetic computer tape or cartridge to the Director on a monthly basis beginning December 7, 1993, the following information concerning policies cancelled for nonpayment of premium and newly issued policies.** These reports shall be provided to the Director in such format and at such times as he or she shall prescribe. The format for said reports is set forth in Appendices A and B, which are incorporated herein by reference.

1.-10. (No change.)

(c) Insurers shall report the cancellation of [personal] private passenger automobile liability coverage for nonpayment of premium after the effective date of the cancellation of a policy.

(d) (No change.)

(e) Insurers shall also report by magnetic computer tape or cartridge (or, for insurers that write less than 750 personal private passenger automobile insurance policies per year in the State of New Jersey, by magnetic computer tape or cartridge or personal computer diskette) to the Director every six months, or at such other interval as may be specified by the Director, the following information concerning all of their current [personal] private passenger automobile insurance policies. These reports shall be provided to the director in such format and at such times as he or she shall prescribe. The format for said reports is set forth in Appendices C and D which are incorporated herein by reference.

1.-6. (No change.)

(f)-(h) (No change.)

(a)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF DENTISTRY

Fees

Proposed Amendment: N.J.A.C. 13:30-8.1

Authorized By: State Board of Dentistry, Agnes M. Clarke, Executive Director.

Authority: N.J.S.A. 45:6-3 and 45:1-3.2.

Proposal Number: PRN 1993-480.

Submit written comments by October 7, 1993 to:

Agnes Clarke, Executive Director
State Board of Dentistry
Post Office Box 45005
Newark, New Jersey 07101

The agency proposal follows:

Summary

In order to cover increased investigative, administrative and program costs incurred by the State Board of Dentistry, the Board is proposing to amend its fee schedule, N.J.A.C. 13:30-8.1, to increase application and biennial registration fees for dentists, dental hygienists and dental assistants.

The proposed fee increases are necessary to prevent a fiscal loss to the Board, which is statutorily required to be self-funding. Specifically, N.J.S.A. 45:1-3.2 requires all professional and occupational licensing boards within the scope of section 1 of Title 45 to raise sufficient fees to cover all proper Board expenses. The statute also requires the Board to fix the fees at a level that will not raise amounts in excess of estimated Board expenses. The proposed fee increases implement these statutory directives. In the unlikely event excess funds are raised, they may be carried over for the benefit of the Board.

Also proposed are five new categories of fees: registration of dentists by reciprocity, registration of dental hygienists by credentials, verification of licensure, duplicate wall certificate and duplicate license. These new fees are necessary to cover Board costs for processing these applications and issuing duplicate licenses.

Social Impact

The proposed fee increases, which will affect all applicants for licensure and current licensees of the Board of Dentistry, are necessary to generate revenues to defray all proper expenses incurred by the Board in fulfilling its statutory obligation to evaluate applicants for licensure and to regulate the practice of dentistry in the State of New Jersey. The new fee schedule will provide the Board with the minimum financial resources to carry on its responsibilities to protect the public health, safety and welfare by ensuring professional competence and the maintenance of high professional standards.

Economic Impact

All dentists, dental hygienists and dental assistants will be affected by these amendments in that they will be required to pay higher application and biennial registration fees. If these fee increases are not implemented at this time, the Board will be unable to continue to comply with its statutory obligation to be self-funding. The Board points out, however, that the fees proposed to be amended have not been raised in four years because substantial unanticipated revenues during the preceding biennial

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period averted the need for licensing fee increases at that time. The Board believes that the biennial registration fee increases—$30.00 per year for dentists and $10.00 per year for dental hygienists and dental assistants—are, as a business expenses, reasonable and therefore does not anticipate higher charges to patients as a result of this amendment.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., individual practicing dentists are deemed to be "small businesses" under the provisions of the Act, the following analysis applies:

The proposed fee increases will affect all of the approximately 10,150 licensed dentists, 2,225 dental hygienists, 1,800 hygienist specialists and 1,200 dental assistants. The only compliance requirement consists of paying increased biennial registration fees in a timely manner. There are no reporting or recordkeeping requirements and no professional services are necessary in order to comply. Since the fees have been set at the lowest amount that will cover the Board's operating expenses, the intent of the Regulatory Flexibility Act to minimize adverse ecocomic impact on small businesses has been implemented.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:30-8.1 Fee schedules

(a) The application fees charged by the Board of Dentistry shall be the following:

1. Dentists	[$75.00] **$125.00**
2. Dental Hygienists	[$50.00] **$75.00**
3. Dental Hygienists—expanded duties supplement	[$10.00] **$25.00**
4. Registered Dental Assistants	[$15.00] **$35.00**

(b) The Biennial Registration fees charged by the Board of Dentistry shall be the following:

1. Dentists:	
i. Active registration	[$100.00] **$160.00**
ii. Inactive registration	[$40.00] **$70.00**
iii. Branch office	[$20.00] **$40.00**
2. Dental Hygienists:	
i. Active registration	[$30.00] **$50.00**
ii. Inactive registration	[$10.00] **$20.00**
iii. Branch office	[$10.00] **$20.00**
3. Registered Dental Assistants	
i. Active registration	[$30.00] **$50.00**

(c) (No change.)

(d) Other fees:

1.-2. (No change.)

3. Registration of dentists by reciprocity—application fee	**$250.00**
4. Registration of dental hygienists by credentials—application fee	**$125.00**
5. Verification of licensure	**$25.00**
6. Duplicate wall certificate	**$50.00**
7. Duplicate license	**$50.00**

(e) (No change.)

(a)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF NURSING

Fees

Proposed Amendment: N.J.A.C. 13:37-12.1

Authorized By: State Board of Nursing, Sister Teresa Harris, Executive Director.

Authority: N.J.S.A. 45:11-24.

Proposal Number: PRN 1993-469.

Submit written comments by October 7, 1993 to:
Sister Teresa Harris, Executive Director
State Board of Nursing
Post Office Box 45010
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Nursing is proposing a general increase in its fee schedule, N.J.A.C. 13:27-12.1, in order to cover increased investigative and program costs associated with the administration of the Board.

Pursuant to N.J.S.A. 45:1-3.2, all professional and occupational licensing boards within the scope of Subtitle 1 of Title 45 are required to be self-funding; that is, operating costs must be met through licensing and other fees. The statute also requires that funds be raised in an amount estimated not to exceed the Board's operating costs. The proposed fee increases implement these statutory requirements and will prevent the Board from operating at a loss.

Amendments are also proposed to reflect a determination of the Division of Consumer Affairs to amend the fee schedules of the professional boards which it regulates in order to accurately and specifically identify the actual elements for which a Board incurs expenses and in order to create a uniform method of assessing and collecting fees.

Specifically, in connection with licensure of professional and practical nurses, paragraph (a)1 has been identified as the Board's application fee, rather than as a "certification for original examination and licensure." An initial, pro-rated license fee has been created so that individuals applying during the second year of a biennial period may pay only one-half of the biennial fee. Three new fees have been designated: reinstatement, change of name or address and written verification of licensure. Because the Board will no longer be issuing temporary work permits, that fee has been deleted from the schedule. Computer-adaptive testing now permits receipt of examination results in a more accelerated manner, obviating the need for the issuance of a temporary work permit for use pending examination results. An additional amendment reflects that the Board will no longer be supplying copies of standards of practice to registered nurses, who will be referred to the American Nursing Association's standards; the Board will continue to issue practice standards for licensed practical nurses for whom no national standards are in place.

In connection with homemaker-home health aide certification, an application fee has been created to cover the Board's administrative staff time required to process applications, and an initial certification fee has been designated for the reasons stated above.

Finally, the proposed amendment includes a fee schedule for the certification of nurse practitioners.

Social Impact

The proposed fee increases will enable the Board to continue to meet its operating expenses and therefore to continue to fulfill its statutory responsibilities under the Nursing Practice Act. The Board's administrative responsibilities under the Act include evaluating applicants for licensure; prescribing standards and curricula for schools of nursing; evaluating and approving courses for affiliation; accrediting schools of professional nursing; approving schools of practical nursing; conducting investigations, studies of nursing and nursing education and related matters; and prescribing standards and curricula for homemaker-home health aide certification. See N.J.S.A. 45:11-24. Continued Board operation will ensure professional competence and the maintenance of high professional standards, for the protection of the public health, safety and welfare.

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Economic Impact

The proposed fee schedule will affect all applicants for licensure or certification, current licensees and homemaker-home health aide and nurse practitioner certificate holders. Because administrative staff time and expense in processing applications for the registered nurse and the licensed practical nurse are the same, the application fee for the licensed practical nurse has been increased $10.00 so that it is consistent with that of the registered nurse. The biennial fee for both the R.N. and the L.P.N. has been increased $20.00, while the endorsement fee has been increased by $10.00 and $20.00 respectively. The homemaker-home health aide biennial certification fee and the endorsement fee have been raised from $5.00 to $10.00, and initial applicants will be required to pay a $20.00 application fee. Program sponsors will be required to pay $100.00, rather than $25.00, for each additional course location. New fees for nurse-practitioners include a $200.00 biennial renewal fee.

These fee increases are expected to yield revenues sufficient to cover the rising expenses generated by the Board's many statutory obligations. As stated, the increases are necessary to prevent a fiscal loss to the Board, which is required by statute to cover its expenses. In accordance with N.J.S.A. 45:1-3.2, the sums to be raised are estimated not to exceed the amount required to cover Board operating costs for the biennial period.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., Nursing Board licensees and certificate holders are deemed "small businesses" within the meaning of the statute, the following analysis is applicable. The analysis is also applicable to sponsors of homemaker-home health aide programs, the majority of which would be considered small businesses under the Act.

The Board of Nursing anticipates that for the 1994 and 1995 fiscal years it will license and/or certify approximately 25,500 practical nurses, 98,500 professional nurses, 15,000 homemaker-home health aides, and 250 nurse practitioners. In addition, it is estimated that approximately 100 entities will apply for approval as sponsors of homemaker-home health aide training programs. The proposed amendments, which constitute a general increase in the Board's fee schedule, do not involve any reporting or recordkeeping nor do they necessitate the retention of professional services for compliance. Rather, compliance requirements consist of paying increased licensing and certification fees in a timely manner. Since the fees have been set at the lowest amount that will cover the Board's operating expenses, the intent of the Regulatory Flexibility Act to minimize adverse economic impact has been implemented.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:37-12.1 Fee schedule

(a) The following fees shall be charged by the Board in connection with licensure of professional and practical nurses.

[1. Certification for original examination and licensure:
i. Professional nurse $50.00
ii. Practical nurse 40.00
2. Certification for reexamination and licensure:
i. Professional nurse 50.00
ii. Practical nurse 40.00]
1. Application fee $50.00
2. Initial license fee
i. If paid during the first year of a biennial renewal period 50.00
ii. If paid during the second year of a biennial renewal period 25.00
3. Licensure by endorsement: **60.00**
[i. Professional nurse 50.00
ii. Practical nurse 40.00]
4. Verification **for endorsement** 30.00
5. Renewal of license (Biennial) [30.00]**50.00**
6. Late renewal of license **(one to 30 days)** [40.00]**50.00**
7. Reinstatement fee (after 30 days) 100.00
[7.]**8.** Duplicate license [10.00]**25.00**
9. Change of name or address 25.00
10. Written verification of licensure 15.00
[8. Temporary work permit 10.00]
[9.]**11.** Notary Fee 5.00
[10.]**12.** Record duplication 5.00
[11.]**13.** Copy of Nurse Practice Act [3.00]**5.00**
[12.]**14.** Copy of **L.P.N.** Standards of Practice [1.00]**3.00**

[(b) An applicant for a homemaker-home health aide certification shall pay a $5.00 fee at the time of application.]

[(c)]**(b)** The following [additional] fees shall be charged by the Board in connection with certification of homemaker-home health aides.

1. Application fee $20.00
[1.]**2.** Program approval fee **for each location at which course is offered** (annual) $100.00
[2. Fee for each additional location at which course is offered (annual) 25.00]
3. Instructor's Manual [10.00]**20.00**
4. Student Manual [3.00]**10.00**
5. Initial certification fee
i. If paid during the first year of a biennial renewal period 10.00
ii. If paid during the second year of a biennial renewal period 5.00
[5.]**6.** Renewal of certificate (Biennial) [5.00]**10.00**
[6.]**7.** Late renewal of certificate 10.00
[7.]**8.** Duplicate certificate 5.00
[8.]**9.** Certification by endorsement [5.00]**10.00**

(c) The following fees shall be charged by the Board in connection with certification of nurse practitioners:

1. Application fee $100.00
2. Initial certification fee
i. If paid during the first year of a biennial renewal period 200.00
ii. If paid during the second year of a biennial renewal period 100.00
3. Renewal of certification (biennial) 200.00
4. Certification by endorsement 200.00
5. Late renewal of certificate (one to 30 days) 50.00
6. Reinstatement fee (after 30 days) 100.00
7. Duplicate certificate 25.00

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF PSYCHOLOGICAL EXAMINERS
Written Examination Fee
Proposed Amendment: N.J.A.C. 13:42-1.2

Authorized By: Board of Psychological Examiners, Leslie Aronson, Executive Director.

Authority: N.J.S.A. 45:14B-44 and 45:14B-45.

Proposal Number: PRN 1993-500.

Submit written comments by October 7, 1993 to:
Leslie Aronson, Executive Director
State Board of Psychological Examiners
Post Office Box 45017
Newark, New Jersey 07101

The agency proposal follows:

Summary

The proposed amendment to N.J.A.C. 13:42-1.2(a)2 increases the written examination fee from $200.00 to $330.00. This amendment is necessary because the American Association of State Psychology Boards has raised the cost per candidate for the administration of the Examination for the Professional Practice of Psychology and because the Board must cover its own increased administrative costs.

Social Impact

The proposed amendment will impact only those applicants who, as a part of the licensure process, must sit for the written examination. The licensing process itself enables only qualified individuals to service the public, thus protecting health and welfare.

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Economic Impact

The Board of Psychological Examiners has been advised of an increase in the written examination fee by the test administrators. The proposed amendment to the Board's fee schedule is necessary to prevent a fiscal loss to the Board, which is required to cover expenses. Individuals seeking licensure will be affected by this increase.

Regulatory Flexibility Statement

The proposed amendment to the Board of Psychological Examiners fee schedule will only affect individual applicants; no regulatory flexibility analysis is, therefore, necessary.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:42-1.2 Fees

(a) Charges for examinations, licensure and other services are:

1. (No change.)

2. Examnation fee: [$200.00] **$330.00** written, $100.00 oral.

3.-10. (No change.)

(b) (No change.)

(a)

DIVISION OF CONSUMER AFFAIRS
BOARD OF VETERINARY MEDICAL EXAMINERS
Examinations
Proposed Amendments: N.J.A.C. 13:44-1.2, 1.3, 1.4 and 2.9

Authorized By: Board of Veterinary Medical Examiners, Marianne Kehoe, Executive Director.

Thomas Sanquini, D.V.M., President.

Authority: N.J.S.A. 45:16-9.7.

Proposal Number: PRN 1993-465.

Submit written comments by October 7, 1993 to:

Marianne Kehoe, Executive Director
State Board of Veterinary Medical Examiners
Post Office Box 45020
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Veterinary Medical Examiners is proposing to amend the manner in which it calculates a passing score for the National Board Examination (NBE) and the Clinical Competency Test (CCT), both of which are prerequisites for sitting for the practical examination. Currently, the NBE and CCT scores are subject to New Jersey conversion criteria, and a candidate may not recieve a subscore of less than 70 percent on more than one of the three test sections. The proposed amendments are necessitated by recent changes made by Professional Examination Service (PES) in the manner in which the examination is scored. The PES examination is developed by veterinarians selected by the American Veterinary Association who work with statisticians/psychometricians employed by PES.

Historically, PES used the norm-referenced (curve) method of evaluating test scores; that is, students' scores were evaluated relative to each other. However, beginning with the December 1992 examination, PES used criterion-referenced testing in which the individual is evaluated against the material, a change which made the examination more difficult. At the same time, PES subscore reports were increased from three to seven, nearly doubling the chances of a candidate failing more than one section. In fact, the failure rate for the NBE and the CCT increased by approximately four to five percent for the December examination. PES has advised that subscores are used only as an indicator to students of their weak areas and that while a subscore may be a reliable indicator of a person's general ability, it cannot be viewed as a solid and defensible score by itself. PES further advised that pass/fail decisions are more reliably made on the basis of total score performance as compared to subscore performance.

Accordingly, the Board is proposing to amend N.J.A.C. 13:44-1.2 and 2.9 in order to accept NBE and CCT total passing scores, without reference to subscores, as one of the criteria for allowing graduates to practice under supervision and to sit for the New Jersey practical and law examinations. Similar amendments are proposed to N.J.A.C. 13:44-1.3 and 1.4 with regard to the criteria for waiver of the law or practical examination, or both.

Social Impact

The proposed amendments create a more statistically reliable method of assessing a candidate's ability to sit for the practical examination which is expected to benefit both the examination candidate and the Board. Deletion of reference to subscores and reliance on a total passing grade as determined by PES should increase a candidate's chances of achieving an overall passing grade, particularly in light of PES' reporting of seven rather than three subscores and its switch to criterion-based testing. At the same time, the Board will be assured that the NBE and CCT scores adequately and reliably gauge a candidate's preparation to sit for the practical examination, the vehicle by which candidates ultimately are judged. The practical examination is administered to approximately 60 to 75 individuals in October and April of each year. A significant benefit will accrue to those individuals who took the December 1992 and April 1993 national examinations and failed more than one section but passed the total examination. The Board has determined that these individuals will now be eligible to sit for the October practical examination and to apply for a temporary permit number 1 to be employed as an assistant under supervision of a licensee.

Economic Impact

Provided they qualify for a temporary permit number 1, approximately 20 individuals who took the December 1992 and April 1993 national examinations and failed more than one section but passed the total examination will reap the obvious economic benefit of gainful employment pending the October administration of the practical examination. The amendments will not have an economic impact on the general public.

Regulatory Flexibility Analysis

A regulatory flexibility analysis pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. is not required inasmuch as the proposed amendments will affect only individual applicants for licensure or waiver of examination. These individuals would not be considered "small businesses" under the criteria of the Act.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:44-1.2 Examinations

(a) (No change.)

(b) As a prerequisite to taking the New Jersey Practical Examination, an applicant shall have attained a **passing** grade [of 70.0]**, as determined by the test sponsor,** on the National Board Examination and the Clinical Competency Test[, calculated according to New Jersey criteria,] within five years preceding application for the New Jersey Practical Examination [and shall not have scored less than 70.0 on more than one section of each test. A score of 69.5 to 69.9 shall not be rounded off to 70.0 in computing a passing score.].

(c)-(h) (No change.)

13:44-1.3 Licensure by waiver of examination

(a)-(b) (No change.)

(c) In addition, the applicant shall file an application for a review of credentials and submit:

1.-2. (No change.)

3. [Submit] National Board Examination and Clinical Competency Test scores through Interstate Reporting Service. [The scores must meet New Jersey standards upon conversion.]

4.-5. (No change.)

(d)-(e) (No change.)

13:44-1.4 Graduates of non-approved veterinary programs

(a) (No change.)

(b) The National Board Examination and Clinical Competency Test taken for the ECFVG Program may be used to fulfill the prerequisite for the State Practical Examination or the State Veterinary Jurisprudence Examination. However, for this purpose the results of the tests [shall meet the New Jersey standards upon conversion and] shall have been obtained within the five year period immediately preceding application.

(c)-(f) (No change.)

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13:44-2.9 Temporary permits

(a) (No change.)

(b) A candidate who has filed an application for a review of credentials, and is waiting to [write] **take** the next scheduled National Board Examination, Clinical Competency Test, the New Jersey Practical Examination, or Veterinary Jurisprudence Examination, may apply to the Board for a temporary permit number 1 to be employed as an assistant under the responsible supervision of a qualified New Jersey licensed veterinarian, except that a person with National Board Examination and/or Clinical Competency Test scores which do not meet New Jersey standards [upon conversion] shall not be eligible to make application.

(c)-(i) (No change.)

(a)

DIVISION OF CONSUMER AFFAIRS

Advisory Board of Public Movers and Warehousemen Late Renewal and Reinstatement Fee Timeframes

Proposed Amendment: N.J.A.C. 13:44D-2.4

Authorized By: Jan C. Gavzy, Acting Director, Division of Consumer Affairs.

Authority: N.J.S.A. 45:14D-6.

Proposal Number: PRN 1993-495.

Submit written comments by October 7, 1993 to:
Diane Romano, Executive Director
Advisory Board of Public Movers and Warehousemen
Post Office Box 45018
Newark, New Jersey 07101

The agency proposal follows:

Summary

The proposed amendment to N.J.A.C. 13:44D-2.4 revises the late renewal and reinstatement fees only in terms of clarifying the timeframe in which those payments pertain. Late fees are payable between day one and day 30 following the license renewal deadline. Thereafter, the presumption is that the Advisory Board has removed the file from the active licensees file and the licensee is no longer licensed. A reinstatement fee will be accepted by the Board from the 31st day until the 60th day following the original license renewal deadline.

While the proposed amendment is an explanatory regulation regarding timeframe, the already existing fees to which the fee-periods would be appended are not to be construed as penalties. Rather, the fees serve to cover the administrative costs that arise from late licensing or license reinstatement. Either of these fees is payable, as necessary, in addition to the annual renewal fee or the initial licensing fee.

Social Impact

The proposed amendment will affect only those licensees who fail to meet the deadline for paying their renewal fee. The amendment does not change the amount of either the late renewal or reinstatement fee, for its entire purpose is to inform licensees of the timeframe within which these fees are applicable as part of the license renewal process.

Economic Impact

The proposed amendment is explanatory in nature and will have no economic impact on licensees of the Board.

Regulatory Flexibility Statement

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-1 et seq., public movers and warehousemen are deemed "small businesses," then within the meaning of the statute, the following statement is applicable:

The proposed amendment to the State Board of Public Movers and Warehousemen fee schedule does not impose any reporting or recordkeeping requirements on licensees. The proposed amendment will also not force licensees into any anticipated initial capital costs, costs for professional services or any other costs of compliance.

Because the amendment is explanatory in nature regarding the timetable when late fees pertain, and because the intent of the amendment is to create uniformity in the profession, the amendment must be applied uniformly without differentiation as to size of practice.

Full text of the proposal follows (additions indicated in boldface **thus**):

13:44D-2.4 Fees

(a) Fees for initial licenses, renewal licenses and copies of licenses shall be as follows:

1.-3. (No change.)

4. Late renewal fee **(0 to 30 days)** $100.00

5. Reinstatement fee **(31 to 60 days)** $200.00 plus the initial license fee.

(b)

DIVISION OF CONSUMER AFFAIRS

State Board of Chiropractic Examiners Scope of Practice

Proposed Amendment: N.J.A.C. 13:44E-1.1

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President.

Authority: N.J.S.A. 45:9-41.23(h).

Proposal Number: PRN 1993-499.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The State Board of Chiropractic Examiners is proposing amendments to N.J.A.C. 13:44E-1.1, Scope of practice, which sets forth not only the methodology but also the diagnostic and analytical procedures that fall within the scope of chiropractic care. The proposed amendments consist of three new subsections, (f), (g) and (h), that will further define the scope of chiropractic care by citing certain theories, modalities, and procedures that lie beyond the pale of chiropractic care. The overriding intent of the proposed amendments is to counteract the surge in the use of unsubstantiated chiropractic theories, modalities and procedures that misrepresent the profession to the public and thereby threaten its credibility and damage its ability to serve the public.

Subsection (f) would prohibit licensees from representing or utilizing an unsubstantiated theory, modality or procedure as constituting chiropractic care. Subsection (f) further outlines some specific factors that the Board may take into consideration in determining whether or not a procedure employed by a licensee is unsubstantiated and thereby exceeds the chiropractic scope of practice. Those factors include whether the theory, modality or procedure is an integrated part of the academic curriculum of accredited chiropractic colleges; whether it is validated, or is as of yet too speculative in nature; and whether it is accepted by a responsible and substantial segment of the chiropractic community. In essence, the threshold that any given theory, modality or procedure needs to cross is that it must have gained either widespread academic, scientific or chiropractic community acceptance. Besides widespread academic, scientific or chiropractic community acceptance, a fourth criterion is created, for the rule specifically notes that the Board need not consider merely those factors and may also consider other factors in determining whether a theory, modality or procedure is unsubstantiated.

Subsection (g) addresses theories, modalities, and procedures specifically identified as excluded from the scope of chiropractic care. This list of unsubstantiated services includes but is not limited to "networking." While subject to additions by the Board, the list will in its present form give both the public and licensees a clear sense of chiropractic theories, modalities and procedures excluded from the scope of chiropractic care.

Subsection (h) states that even if a theory, modality or procedure is not specifically identified in subsection (g), the Board may decide that it is unsubstantiated and take action pursuant to subsections (f) and (g).

Social Impact

Given the recent increase in unsubstantiated services being offered to the public by some licensees, the proposed amendment will undoubtedly have a major social impact. Patients and the public at large are likely to experience the impact in the following two ways: through a

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severe if not complete reduction in licensees who offer the unsubstantiated services because they know they would otherwise be operating outside the scope of chiropractic care, and a corresponding decrease in confusion as to what services constitute chiropractic care. The decrease in confusion should result because licensees will no longer be permitted either to represent or bill for unsubstantiated chiropractic services, conduct that inevitably attempts to conflate those services with legitimate chiropractic care.

The reduced confusion should aid the public to make more informed decisions as to whether to pay an individual offering services that are not within the scope of chiropractic care.

Economic Impact

The economic impact of the proposed amendment will be felt primarily by licensees who are currently offering or engaging in unsubstantiated chiropractic services, and who will not be able to do so under the proposed amendment to the scope of chiropractic care.

For its part, the public will also be indirectly affected by the proposed amendment. The public stands to benefit from greater clarity regarding the scope of chiropractic care because such clarity should eliminate payments for unsubstantiated services, thereby enabling insurance companies to realize savings that may be passed on to consumers.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The proposed amendment, which governs and defines theories, modalities and procedures that are unsubstantiated and cannot be offered or represented either as chiropractic care or as the basis of reimbursement, will apply to all of the approximately 3,000 current licensees of the Board of Chiropractic Examiners. No reporting or recordkeeping is required, nor does the amendment require initial capital costs or the retention of professional services or any other costs of compliance. The only compliance requirement is adherence to the proposed amendment.

The Board considers the amendments to be reasonable and to be the minimum necessary for the protection of the public health, safety and welfare. For that reason, the proposed amendment must be uniformly applied to all licensees without differentiation as to size of practice.

Full text of the proposed amendment follows (additions indicated in boldface **thus**):

13:44E-1.1 Scope of practice

(a)-(e) (No change.)

(f) A licensee in the course of the practice of chiropractic shall not utilize, represent or hold out the use of, or advertise in any manner any unsubstantiated theory, modality or procedure. In making the determination that an unsubstantiated theory, modality or procedure exists, the Board shall consider factors including, but not limited to, whether a theory, modality or procedure has gained either widespread academic, scientific or chiropractic community acceptance, as follows:

1. The theory, modality or procedure is not taught as part of the core curriculum or in a regular course for credit in a school approved by the Board pursuant to N.J.S.A. 45:9-41.6. For the purpose of this rule, the fact that a theory, modality or procedure is or has been offered in a one-time not for credit or not regularly scheduled seminar, lecture or program shall not suffice. The theory, modality or procedure must be integrated into the academic curriculum of an accredited chiropractic college;

2. The efficacy or claimed effects of the theory, modality or procedure are too speculative or experimental to permit the identification of the theory, modality or procedure with the practice of chiropractic. "Claimed effects" may include claims made by or attributable to a chiropractor by his or her words or action;

3. The theory, modality or procedure is not accepted by a responsible and substantial segment of the chiropractic community; or

4. Other factors the Board deems relevant in determining whether a theory, modality or procedure is unsubstantiated.

(g) The following theories, modalities and procedures, including diagnostic analytical and treatment procedures, are found to be unsubstantiated:

1. "Networking" or "network chiropractic," combined with unsubstantiated or speculative claimed effects;

2. Craniopathy or craniology;

3. Arm-mentoring/surrogate testing;

4. Any technique which purports to utilize procedures involving the patient's electromagnetic field, including but not limited to "harmonic therapy"; and

5. Applied kinesiology as applied to the visceral organs or for nutritional analysis.

(h) In addition to the theories, modalities and procedures specified in (g) above, the Board may determine in an administrative hearing conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, that a theory, modality or procedure including, but not limited to, those set forth above in (g) above is unsubstantiated and therefore not within the scope of chiropractic, and that a licensee has committed a violation of N.J.S.A. 45:1-21 by having utilized such a procedure or by not complying with the provisions of (f) and (g) above.

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Advertising
Proposed Amendment: N.J.A.C. 13:44E-2.1

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President.

Authority: N.J.S.A. 45:9-41.23(h).

Proposal Number: PRN 1993-498.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The State Board of Chiropractic Examiners is proposing amendments to N.J.A.C. 13:44E-2.1, Advertising, which sets forth the specific standards that govern and define advertising conduct. The proposed amendments consist of two new provisions, the first of which appears as text that augments paragraph (c)9 and the second of which appears as new subsection (h). Together, these two provisions will further govern advertising practices in relation to chiropractic treatment and fees.

Paragraph (c)9 prohibits the advertisement of any guarantee that services rendered will result in a cure. The proposed amendment would require chiropractors who advertise a group of symptoms, signals or warning signs that may be helped by chiropractic care to include disclaimer language. The disclaimer language would alert the public to the fact that said symptoms, signals or warning signs may involve conditions which may not be amenable to chiropractic care. The addition to paragraph (c)9 is born of twin motives. The disclaimer language aids the public by alerting it to the possibility that chiropractic care may have limited effect, while also protecting the integrity of chiropractors from charges that they exaggerate the healing potential of chiropractic care.

Proposed new subsection (h) concerns advertisements about free or discounted initial examinations. Its purpose is to protect the interest of the patient who responds to an advertisement offering a free or discounted initial examination by ensuring that he or she will get the very same diagnostic or analytical services normally performed by a chiropractor for any fee-generating patient prior to treatment.

Paragraph (h)1 would not permit chiropractors who advertise free or discounted services to limit those services to patients with coupons except in those instances in which the advertisement is in coupon form. Any person who comes to a chiropractor for treatment during the time when the advertisement is in effect is guaranteed free or discounted services regardless of whether or not the patient knew about the advertisement in question.

Paragraphs (h)2 and 3 provide a safeguard mechanism that protects both the public and the integrity of the chiropractic profession by

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preventing dishonest chiropractors from attempting either to simulate or exploit actual emergency situations. The intent here is to avoid situations in which a chiropractor uses the free or discounted initial examination as the occasion for trumpeting symptoms that supposedly require immediate emergency treatment, thereby transforming a patient's free or discounted visit to a chiropractor into an opportunity for the chiropractor to charge that patient substantial fees.

Thus paragraph (h)2 establishes the prohibition against charging for services rendered during a period of 72 hours from the time the advertised free service was rendered. The prohibition contains an escape clause, however, for the prohibition does not cover emergent services that would go beyond the rubric of services normally performed for diagnostic or analytical purposes.

Paragraph (h)3 states that even in case of an emergency, chiropractic fees may not be charged unless the patient signs a waiver voiding the 72-hour restriction. The waiver form that would then need to be signed by a patient authorizing paid chiropractic care because of an emergency condition is included in paragraph (h)3.

Social Impact

Both of the new provisions will have a social impact. In the case of the disclaimer language, consumers will benefit from knowing that chiropractic care may not necessarily relieve the ailments they suffer from, thus permitting them to make a more reasoned judgement as to whether or not to seek chiropractic care.

The provision concerning free or discounted services for an initial examination is also in the public interest. The provision aims to ensure a wide range of patients that they will receive, as advertised, proper diagnostic or analytical treatment that will not serve as merely a pretext for fabricated "emergency" treatment that is likely to generate egregious professional fees.

Economic Impact

Although the main purpose of the proposed amendments is their social impact, the disclaimer-language provision may have a beneficial economic impact on consumers and insurance companies simply because consumers may be saved chiropractic expense in those cases when chiropractic care may not be effective.

As for licensees, the disclaimer language provision does offer advertising chiropractors some protective cover in case of disappointed patients. At the same time, it might potentially cause a dropoff in prospective patients, who may have been made wary of seeking chiropractic care because of fears that such care may not cure them of their ills.

The free-or-discounted services provision will also have an economic impact on chiropractic patients, but of an entirely beneficial nature. Patients should no longer be as subject to bait-and-switch tactics or to fees that arose from supposed or genuine emergency situations in which a waiver-form mechanisms was not in place to protect them from being confronted with unanticipated billings.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses," then within the meaning of the statute, the following statement is applicable:

The proposed amendment, which governs and defines advertising conduct and the chiropractic treatment and fees that accompany it, will apply to all licensees of the Board of Chiropractic Examiners.

The proposed compliance requirements relate generally to including disclaimer language in any chiropractic advertisement and to specific requirements with regard to free or discounted initial services. No professional services are likely to be needed for compliance with either the disclaimer-language provision or the free-or-discounted services provision.

The Board considers these requirements to be reasonable and to be the minimum necessary for the protection of the public health, safety and welfare. For that reason, the proposed amendments must be uniformly applied to all licensees without differentiation as to size of practice.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:44E-2.1 Advertising

(a)-(b) (No change.)

(c) A licensee who engages in the use of advertising which contains the following shall be deemed to be engaged in professional misconduct:

1.-8. (No change.)

9. Any guarantee that services rendered will result in a cure [; or]**. Thus when an advertisement lists a group of symptoms, signals or warning signs that may be helped by chiropractic care or may be related to vertebral subluxation and/or their effects upon spinal nerves, the following disclaimer langauge shall accompany the list in a type size clearly legible:**

"Any of the above signs may be associated with conditions which may not be amenable to chiropractic care;" or

10. (No change.)

(d)-(g) (No change.)

(h) A Board licensee shall include in an initial examination advertised as free or discounted all ancillary services, including, but not limited to, x-rays, normally performed for diagnosis or analysis prior to treatment by the advertising licensee in his or her general practice. For purposes of this subsection, advertisement of a free or discounted "initial examination" shall include advertisement of a free or discounted "consultation" and other similar terms.

1. Unless the advertisement for free or discounted services is in coupon form or otherwise requires the patient to present the advertisement or reference to the advertisement to the licensee in order to secure the services free of charge or discounted, the licensee shall give the free or discounted services to all patients receiving initial examinations during the period of validity of the advertisement.

2. Except as set forth in (h)3 below, the licensee shall not charge for any service rendered during a period of 72 hours from the time the advertised free service was rendered.

3. In the event the patient is in need of emergency treatment, the licensee shall not charge for any such services for a period of 72 hours from the time the advertised free service was rendered unless the practitioner obtains a signed waiver from the patient. The waiver shall be in the following form:

I have responded to an advertisement for a free initial examination with Dr. John Jones, D.C. Dr. Jones has explained to me that, under the regulations of the N.J. Board of Chiropractic Examiners, he cannot charge for any service for a period of 72 hours from the time he gives me the free examination unless there is an emergency need for services and I sign this waiver.

I have what I believe is a need for emergency treatment. Therefore, I agree to sign this waiver and to pay for treatment within the 72 hour period. The amount Dr. Jones will charge me for treatment is $___.00. This figure was written onto the line before I signed this waiver.

I have been given a copy of this waiver by Dr. Jones or someone from his office. If I have any concerns, I can write to the Board of Chiropractic Examiners, 124 Halsey Street—6th Floor, Newark, New Jersey 07101.

Patient's signature_____

Patient's name printed_____

Date_____

Recodify existing (h)-(l) as **(i)-(m)** (No change in text.)

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(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Practice Identification
Advertising in Special Area
Reproposed New Rule: N.J.A.C. 13:44E-2.6

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President.
Authority: N.J.S.A. 45:9-41.23(h).
Proposal Number: PRN 1993-497.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

Based on public comment received during the 30-day comment period, the State Board of Chiropractic Examiners is reproposing a new rule, N.J.A.C. 13:44E-2.6, entitled "Practice Identification." The rule was originally proposed on June 17, 1991. (See 23 N.J.R. 1896(a)).

Subsection (a) of the reproposed rule defines the academic guidelines by which a licensee shall be deemed to have earned either a chiropractic certificate or diplomate. The educational requirements adhere to commonly acknowledged national standards that serve as the basis for assuring the public that when chiropractors identify themselves and their acquired degrees for professional purposes, they will do so only after having fulfilled programs of study that meet with the Board's approval.

Subsection (b) of the reproposed rule requires licensees to identify themselves for professional purposes in a manner clearly indicating the chiropractic profession and advises licensees of the terms which may be used to do so. While the reproposed rule contains provisions similar to those provided by the Board of Medical Examiners, which previously regulated the practice of chiropractic in New Jersey, it differs from the latter in requiring that the identifying term appear immediately adjacent to the full name of the licensee.

Subsection (c) of the reproposed rule is intended to address the confusion and ambiguity which results from a string of letters appearing immediately after the name of the licensee. This reproposed rule would permit the use of such letters in immediate conjunction with the name of the licensee only if the letters represent an earned academic professional degree. Letters representing non-academic degrees or professional society memberships may not appear in immediate conjunction with the name.

Subsections (d) and (e) of the reproposed rule further address the specific manner in which a licensee must advertise his or her earned academic professional degree. Subsection (d) requires that all claims of certification or diplomate status must include the full name of the agency that provided the degree, while subsection (e) honors the National Board of Chiropractic Examiners' request to prohibit licensees from creating advertisements that use the term "Diplomate of National Board of Chiropractic Examiners." The prohibition protects against a deceptive practice; namely, a claim of diplomate status which suggests and implies specialized, advanced training when, in fact, a diplomate from the National Board merely reflects passage of the National Board's exam. In addition, the reproposed rule's emphasis on proper credentials properly presented extends to include the provision that licensees shall, upon request of the State Board, validate their advertised claims of having achieved certification or diplomate status.

Subsections (f) and (g) of the reproposed rule specifically concern the manner in which chiropractors who advertise themselves as specialists shall identify themselves for professional purposes. Together, these two subsections stress the fact that the term "chiropractic" must be used in conjunction with specialty claims in order to assure that the consumer will not be misled and believe that the advertiser is a medical doctor rather than a chiropractor. In seeking to clarify specialty claims, subsection (g) calls on licensees to place the term "chiropractic" before any specialty designation in an advertisement. Finally, in order to ensure that subsections (f) and (g) and all other provisions of this reproposed rule will be honored, subsection (h) imposes the penalty that a licensee who violates any of the provisons of this rule will be deemed to have engaged in professional misconduct.

Social Impact

The reproposed rule protects consumers in a number of positive ways. The Board's decision to clarify the educational requirements that licensees who advertise diplomate status must meet, seeks to guarantee the consumer relying upon such information of being served by chiropractors whose educational backgrounds comply with national academic standards. Just as helpful from the consumer's point of view is that in requiring the use of standardized identifying terms immediately adjacent to a licensee's name and in limiting the use of letters which may follow a licensee's name to letters representing earned academic degrees, the reproposed new rule should alleviate consumer confusion and more readily enable the consumer to identify members of the chiropractic profession and the agency that conferred the credentials upon which the licensee's claim to professional status is based.

Consumer confusion should be further reduced by provisions that require specialty claims to be placed in conjunction with the term "chiropractic" and for the claims to be advertised only by chiropractors who limit or restrict their practice to the specialty area. The reproposed rule will also benefit licensees, in that they will be clearly advised of the Board's requirements in connection with practice identification so as to avoid charges of professional misconduct.

Economic Impact

The reproposed rule should have no economic impact on the general public because it merely provides guidance to chiropractic licensees as to the manner in which they are to identify themselves for professional purposes. The individuals who may be economically affected by the reproposed rule consist merely of those licensees who ignore the reproposed rule's provisions and may therefore face whatever penalties or remedies the Board imposes on chiropractors whose actions have been deemed professional misconduct.

Regulatory Flexibility Analysis

If for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The reproposed rule will apply to all of the approximately 3,000 current licensees of the Board of Chiropractic Examiners. Compliance with the rule involves no recordkeeping requirements, nor does it require the retention of professional services. However, the rule does involve the potential for a limited amount of once-only reporting since a licensee shall, upon request, provide the Board with proof of having met the educational requirements. Nevertheless, such substantiation should be easily achieved, and there are no initial capital costs or other costs of compliance.

In essence, the reproposed rule merely advises licensees of the manner in which they are to identify their practices for professional purposes. Since the intent of the rule is to create uniformity in the profession with regard to practice identification and to avoid consumer confusion, the reproposed rule must be applied uniformly without differentiation as to size of practice.

Full text of the proposed new rule follows:

13:44E-2.6 Practice identification

(a) The following words and terms, when used in this section, shall have the following meanings unless the context clearly indicates otherwise.

1. "Certified" or "certifications" means that a licensee shall have earned a certificate upon satisfactory completion of a program approved by the American Chiropractic Association (ACA), International Chiropractic Association (ICA), or the Federation of Straight Chiropractic Organizations (FSCO) in a Board approved school, college or institution of chiropractic in an area of study which is within the scope of chiropractic in this State, and that the licensee shall have fulfilled all requirements of the agency granting the certification.

2. "Diplomate" means that a licensee shall have earned a diplomate upon satisfactory completion of a program approved by ACA, ICA or FSCO in a Board approved school, college or institution of chiropractic in an area of study which is within the scope

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of chiropractic in this State, and that the licensee shall have fulfilled all requirements of the agency granting the diplomate.

(b) A licensee of the Board of Chiropractic Examiners shall be identified for professional purposes (office identification, stationery, professional cards, signature on insurance claim forms, education, advertising, indoor and outdoor signs, etc.) in a manner clearly indicating the chiropractic profession immediately adjacent to the full name of the licensee by using the term chiropractor, doctor of chiropractic, chiropractic physician, or the abbreviation D.C. as the degree actually conferred by a professional college.

(c) The use of any letters in immediate conjunction with the name of a licensee shall be deemed a representation of an earned academic professional degree or certification or diplomate status as defined in (a) above. The use of any letters which represent non-academic degrees or certifications or abbreviations of membership in professional societies and associations which are not of certification or diplomate status as defined in (a) above shall not be used in immediate conjunction with the name of the licensee.

(d) Any licensee who claims certification or diplomate status in an area of chiropractic in any advertisement shall have met the educational requirements as set forth in (a) above. All such claims shall also contain the full name of the agency conferring the certification or diplomate, for example, Diplomate American Board Chiropractic Orthopedics. A licensee shall, upon request, provide the Board with substantiation of proper credentials to claim certification or diplomate status.

(e) The use of the term "Diplomate of National Board of Chiropractic Examiners" by a licensee in an advertisement shall be prohibited.

(f) The use of "specialist," "specializing in . . .," or any other word or phrase connoting that the licensee has advanced training and education in any advertisement shall be permitted only by those licensees who have achieved certification or diplomate status as defined in (a) above and who, in fact, limit or restrict their practice to the specialty area.

(g) The use of a specialty term in any form of advertising by any licensee must be preceded by the term "chiropractic," for example, "chiropractic orthopedics," "chiropractic sports injuries," "chiropractic neurology."

(h) Any violation of the provisions of this section shall be deemed professional misconduct.

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Duties of Unlicensed Assistants
Proposed New Rule: N.J.A.C. 13:44E-2.8

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President.

Authority: N.J.S.A. 45:9-41.23(h).

Proposal Number: PRN 1993-496.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Chiropractic Examiners is proposing a new rule, N.J.A.C. 13:44E-2.8, in order to identify for its licensees the duties which an unlicensed assistant may perform under the direct supervision of a chiropractor.

Subsection (a), defining "unlicensed assistant" and "direct supervision," sets forth the responsibility of the delegating chiropractor to make all judgments associated with the performance of the delegated duties and to remain on the premises while such duties are performed.

Subsection (b) delineates the duties which may be delegated to unlicensed assistants. The Board considers the list to be exclusive but may expand it from time to time as circumstances require. In identifying delegable physical modalities (paragraph (b)9), the Board has implemented the provisions of P.L. 1990, c.68. Signed into law on July 17, 1990, this legislation prohibits the use of unlicensed employees to administer the following physical modalities: ultraviolet (B and C bands) and electromagnetic rays including, but not limited to, deep heating agents, microwave diathermy, short-wave diathermy and ultrasound. While under the jurisdiction of the Board of Medical Examiners, chiropractors were permitted to delegate some of these physical modalities to unlicensed assistants under certain circumstances pursuant to N.J.A.C. 13:35-6.14. However, that regulation was superseded by P.L. 1990, c.68 and chiropractors may now delegate only those physical modalities identified in paragraph (b)9.

Subsection (c) codifies existing Board policy that a chiropractor may not permit an unlicensed individual to perform massage given as part of the chiropractic treatment. It is the Board's position that professional board oversight with regard to all aspects of chiropractic treatment, including massage, protects the patient. Therefore, massage performed as part of chiropractic treatment may be performed only by a licensed health care provider. Certification in massage from a school or association is not the equivalent of licensure in a health care profession, and this proposal clarifies that individuals holding such certification may not perform massage as part of a chiropractic treatment.

Subsection (c) also prohibits a licensee from permitting an unlicensed assistant to examine, diagnose or analyze a patient, perform x-rays (unless permitted by the Department of Environmental Protection and Energy) or perform a chiropractic adjustment. The Board is concerned that some licensees may be under the misconception that these activities may be performed by a student of a chiropractic college or a graduate of a chiropractic college who has not been licensed in New Jersey. Therefore, the definition of "unlicensed assistant" set forth in subsection (a) specifically includes a student or graduate of a chiropractic institution.

Subsections (d) and (e) set forth the licensee's obligation to write all instructions on the patient chart and to assure that those following through on the instructions have attained sufficient training and competence in performing those tasks.

Social Impact

The proposed new rule will have a beneficial impact on licensees in that it clarifies which duties may be delegated to unlicensed assistants and eliminates any uncertainty in that regard. While subsection (b) limits the physical modalities which a chiropractor may delegate to an unlicensed individual, thus requiring either the licensee to perform these services or the patient to obtain these services at locations which they may not find as convenient, the Board is required to so limit its licensees in order to effect the changes required by P.L. 1990, c.68.

The proposed rule requires licensee adherence to a standard of supervision and oversight designed to ensure a high level of professional care for the chiropractic patient. Patient safeguards include the requirement that the licensee be present at all times when an unlicensed individual is engaged in delegated duties so as to ensure that the unlicensed individual has a satisfactory level of education and competence with regard to each duty delegated.

Economic Impact

Implementation of this rule should not have substantial economic impact upon either the licensee or the general public in view of the fact that the proposed rule merely codifies existing Board policy and statutory prohibitions against unlicensed practice. Any expenses incurred by the chiropractor to ensure the competence of unlicensed individuals performing delegated duties and to provide appropriate instruction and supervision are, in the Board's opinion, more than outweighed by the patient safeguards the rule provides.

The individuals whom the rule will affect economically, and in an adverse manner, are any and all massage therapists who have been at least occasionally working in conjunction with chiropractors. Given their current unlicensed status in the state of New Jersey, massage therapists will under this rule no longer be allowed to derive income from assignments to give massage therapy to the patients of licensees.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses" within the meaning of the statute, the following statements are applicable:

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The proposed rule will affect all of the approximately 3,000 chiropractors currently licensed by the Board and an unknown number of other chiropractic office personnel.

The rule requires licensees to delegate only those duties listed in subsection (b); to ensure that the unlicensed individual performing such duties is competent; to write all instructions on the patient's chart; and to be physically present at all times during the performance of the delegated duties. Initial and annual costs of compliance are expected to be minimal inasmuch as these requirements are within the norm of standard office practice. As stated, the proposed rule merely codifies existing Board policy and statutory requirements with regard to permissible delegation. The services of other professionals would not be needed in order to comply. Since the rule seeks to promote and protect the public health and welfare by setting standards for delegation of duties to unlicensed individuals, no differentiation in compliance based upon licensee size is provided.

Full text of the proposed new rule follows:

13:44E-2.8 Duties of unlicensed assistants

(a) The following words and terms, when used in this section, shall have the following meanings unless the context clearly indicates otherwise:

1. "Unlicensed assistant" means any person, including a student or graduate of a chiropractic institution, who does not hold a valid New Jersey chiropractic license.

2. "Direct supervision" means that the licensee shall be physically present in the office at all times during which an unlicensed individual is engaged in delegated duties and that the licensee shall retain full professional responsibility for patient care and treatment.

(b) An unlicensed assistant may perform only the following duties under the direct supervision of a licensed chiropractor:

1. Complete a medical history with the patient;
2. Prepare the patient for the chiropractic treatment to be rendered by the licensee;
3. Write into the patient record subjective complaints from the patient and objective findings provided by the licensee;
4. Perform a urinary dipstick analysis;
5. Take and record temperature, height and weight;
6. Prepare x-ray films and develop x-ray films;
7. Provide a patient education activities;
8. Provide instruction in activities of daily living; and
9. Administer cryotherapy, hot packs, hydrotherapy, and mechanical traction.

(c) A licensee shall not permit an unlicensed assistant to examine, diagnose or analyze a patient, or to perform massage, x-rays (unless permitted by the Department of Environmental Protection and Energy), physical modalities, other than those listed in (b)9 above, or to perform a chiropractic adjustment.

(d) The licensee shall write all instructions for duties to be performed by unlicensed assistants on the patient's chart and shall make the chart available at all times to the unlicensed assistant carrying out the instructions.

(e) The licensee shall provide instruction to and shall ascertain a satisfactory level of education and competence of, each unlicensed assistant in regard to each duty used in the licensee's office prior to ordering the duty to be performed.

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Notification of Change of Address; Service of Process
Proposed New Rule: N.J.A.C. 13:44E-2.9

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President

Authority: N.J.S.A. 45:9-41.23(h).

Proposal Number: PRN 1993-472.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The State Board of Chiropractic Examiners is proposing a new rule, N.J.A.C. 13:44E-2.9, Notification of change of address; service of process. From time to time it is necessary for the Board to contact its licensees. For example, it may be necessary to notify licensees of any significant changes in the law. The biennial renewal forms specify that any change in address must be communicated to the Board, and in addition N.J.S.A. 45:9-41.11 places a clear affirmative duty on a licensee to provide such notice within 10 days of the change. The proposed rule establishes the mechanics of the notice already required by that statute.

Subsection (a) requires a licensee to notify the Board, by certified mail, return receipt requested, of any address change within 10 days following a change. Subsection (b) provides that service of process at the licensee's current address on file with the Board will be deemed adequate notice for the purposes of commencing a disciplinary action.

Social Impact

In requiring a licensee to notify the Board of any change of address, the proposed new rule will enhance the Board's ability to contact its licensees. Licensees will also benefit in that they will receive important information quickly.

Economic Impact

The cost of a certified mailing will be incurred by licensees who are required under this proposed new rule to notify the Board of an address change. No economic impact upon the public is anticipated.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The proposed new rule will apply to all of the approximately 3,000 current licensees of the Board of Chiropractic Examiners. Compliance with the rule involves only reporting to the Board any change of address within 10 days of the change. There are no initial capital costs and no professional services will be needed in order to comply. No differentiation in requirements based upon business size is provided, since to do so would adversely impact the regulation's intent to have up-to-date addresses for all Board licensees. In any event, the cost of compliance will be only the nominal cost of a certified mailing.

Full text of the proposed new rule follows:

13:44E-2.9 Notification of change of address; service of process

(a) A licensee of the Board of Chiropractic Examiners shall notify the Board in writing of any change of address from the address currently registered with the Board and shown on the most recently issued certificate. Such notice shall be sent to the Board by certified mail, return receipt requested, not later than 10 days following the change of address.

(b) Service of an administrative complaint or other Board-initiated process at a licensee's address currently on file with the Board shall be deemed adequate notice for the purposes of N.J.A.C. 1:1-7.1 and the commencement of any disciplinary proceedings.

(b)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Display of License; Right to a Hearing
Proposed New Rules: N.J.A.C. 13:44E-2.10 and 2.11

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President.

Authority: N.J.S.A. 45:9-41.23(h).

Proposal Number: PRN 1993-473.

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Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The State Board of Chiropractic Examiners is proposing two new rules: N.J.A.C. 13:44E-2.10, Display of license, and N.J.A.C. 13:44E-2.11, Right to a hearing.

The proposed display of license rule would require every chiropractor in the State of New Jersey to display his or her license and the current renewal certificate in a manner easily spotted by patients entering the licensee's principal office or place of business. Should the licensee practice in an additional facility or facilities, a copy of the current renewal certificate would also need to be displayed there. The purpose of the proposed display of license rule is to provide assurance to patients that the chiropractor who is rendering treatment is duly licensed and currently registered to practice chiropractic in New Jersey.

The proposed right to a hearing rule concerns the right of any licensee to a hearing in any case involving the suspension, revocation or refusal to renew a license. This rule merely codifies for regulatory purposes the rights which are set forth in the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

Social Impact

The proposed display of license rule would have significant social impact in that it provides patients with hard evidence of licensure status and thereby removes the burden of patients making an independent inquiry in order to obtain this information. The proposed right to a hearing rule has no social impact on the general public though, for it is informative only. It benefits licensees by informing them of their right to a hearing if facing the possible suspension, revocation or refusal by the Board to renew their licenses.

Economic Impact

Neither of these proposed new rules will have any economic impact on consumers. Instead, their economic impact will be limited to chiropractors and then only in the case of the display of license rule, for it means that any and all licensees with more than one place of business will incur the $25.00 duplicate license fee for each place of business.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The two proposed rules will apply to all of the approximately 3,000 current licensees of the Board of Chiropractic Examiners. Compliance with both rules will not involve either recordkeeping or reporting, nor will compliance require the retention of professional services. In addition, there will be no initial capital costs or other costs of compliance pursuant to the right to a hearing rule, though the display of license rule will result in compliance costs because of the fee for duplicate copies.

Since the intent of both rules is to create uniformity in the profession, by assuring patients that practicing chiropractors are currently registered while also informing chiropractors of their right to a hearing when facing the possible loss of their licensure status, the proposed rules must be applied uniformly without differentiation as to size of practice.

Full text of the proposed new rules follows:

13:44E-2.10 Display of license

Each person holding a license to practice chiropractic in the State of New Jersey shall display the license and the current renewal certificate in a conspicuous place in his or her principal office or place of practice. In addition, the licensee shall display a copy of the current renewal certificate in all other facilities where the licensee practices.

13:44E-2.11 Right to a hearing

Prior to any suspension, revocation or refusal to renew a license, the licensee shall have the right to request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Overutilization; Excessive Fees
Proposed New Rule: N.J.A.C. 13:44E-2.13

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President.

Authority: N.J.S.A. 45:9-41.23(h).

Proposal Number: PRN 1993-475.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Chiropractic Examiners has been presented with many complaints from patients, licensees and insurance carriers alleging that there has been an overutilization of chiropractic services and/or that the fees are excessive to the point of being outrageous. The purpose of the proposed new rule is to codify the Board's policy that overutilization of chiropractic services for the purpose of exploiting a patient or a third party payor for the financial gain of the licensee is unprofessional and undermines the public's confidence in the profession as a whole.

This new rule sets forth those practices which the Board considers overutilization and includes the charging of unconscionable fees. Specifically, paragraph (a)4 details seven factors that may be considered by the Board when it reviews the question of whether unconscionable fees have been incurred by a patient.

Meanwhile, paragraphs (a)1 through 3 address unjustified services; services, goods or appliances that are excessive in quality or quantity; and multiple charges for the same service, treatment, goods or appliances. Paragraph (a)5 covers services, goods or appliances not rendered or supplied but for which fees were nevertheless incurred by a patient. Paragraph (a)6 prohibits excessive charges motivated by insurance coverage, and paragraph (a)7 prohibits licensees from billing or submitting a claim for the application of an unsubstantiated theory, modality or procedure.

Social Impact

The proposed new rule is anticipated to have a positive social impact in that it should reduce the incidence of unnecessarily prolonged treatment as well as the charging of excessive fees for chiropractic services. The rule advances current efforts to reduce health care costs, and is also a reflection of the Board's efforts to maintain the highest ethical and professional standards. For example, billing for services or appliances never supplied is not only fraudulent but destructive to the public's perception of professionalism on the part of its health care providers. The proscription of such improper practices can only be of benefit to the public and to licensees, who will be provided with a clearly articulated code aimed at preventing overutilization as well as excessive fees.

Economic Impact

Overutilization obviously inflates the cost of health care services, and increases without justification amounts paid by patients or reimbursed by third-party payors. In the latter case, the cost is ultimately borne by the consumer in the form of higher insurance premiums or taxes. By identifying those practices that may directly or indirectly "gouge" the consumer, the proposed new rule clearly benefits the public. It will result in economic detriment only to that small number of practitioners who may presently be engaged in the prohibited acts.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors are deemed "small businesses" within the meaning of the statute, the following statements are applicable:

The proposed new rule will affect all of the approximately 3,000 chiropractors currently licensed by the Board of Chiropractic Examiners. The rule does not impose reporting, recordkeeping or other compliance requirements upon licensees, but rather defines the parameters of overutilization of services.

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Since the intent of the rule is to create uniformity in the profession by preventing the overutilization of chiropractic services, the proposed rule must be applied identically without differentiation as to size of practice.

Full text of the proposed new rule follows:

13:44E-2.13 Overutilization; excessive fees

(a) A licensee shall not directly or indirectly engage in the rendering of any bill or the submission of any claim for service which:

1. Is not justified by the needs of the patient;

2. Is for any diagnostic or treatment services, goods or appliances which are excessive in quality or quantity;

3. Represents multiple charges for the same chiropractic services or treatments, good or appliance;

4. Contains an excessive fee. A fee is excessive when, after a review of the facts, a licensee of ordinary prudence would be left with a definite and firm conviction that the fee is so high as to be manifestly unconscionable or overreaching under the circumstances. The charging of an excessive fee shall constitute professional misconduct pursuant to N.J.S.A. 45:1-21. Factors which may be considered in determining whether a fee is excessive include, but are not limited to, the following.

i. The time and effort required;

ii. The novelty and difficulty of the procedure or treatment;

iii. The skill required to perform the procedure or treatment properly;

iv. Any requirements or conditions imposed by the patient or by circumstances;

v. The nature and length of the professional relationship with the patient;

vi. The experience, reputation and ability of the licensee performing the services; and/or

vii. The nature and circumstances under which services are provided.

5. Is for services, goods or appliances which were not rendered or supplied;

6. Is for a charge or claim which, due to the presence of insurance coverage, exceeds the usual and customary charges for such services, goods or appliances for patients who do not have insurance coverage; or

7. Is for any service identified or identifiable as an unsubstantiated theory, modality or practice.

(a)

DIVISION OF CONSUMER AFFAIRS STATE BOARDS OF CHIROPRACTIC EXAMINERS AND PHYSICAL THERAPY

Referral of Patients to Physical Therapists

Proposed New Rules: N.J.A.C. 13:39A-2.5 and 13:44E-2.14

Authorized By: Board of Chiropractic Examiners, Alfred Davis, D.C., President, and Board of Physical Therapy, Susan H. Gaitland, Executive Director.

Authority: N.J.S.A. 45:9-37.18(f) and 45:9-41.23(h).

Proposal Number: PRN 1993-474.

Submit written comments by October 7, 1993 to:
Jay Church, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agencies' proposal follows:

Summary

The Board of Chiropractic Examiners and the Board of Physical Therapy are proposing parallel new rules that will govern the referral of patients to physical therapists by chiropractors. The joint proposed new rules are the result of a series of interdisciplinary meetings between representatives from the two boards. Together, chiropractic rule N.J.A.C. 13:44E-2.14, Referral of patients to physical therapists, and N.J.A.C. 13:39A-2.5, Referral of patients by chiropractors, clarify the professional relationship between chiropractors and physical therapists in regard to referrals by establishing the procedure to which both sets of professionals will adhere.

In general terms, the jointly proposed rules are based on three principles: chiropractors may, indeed, make referrals to physical therapists; physical therapists should not uniformly refuse to accept referrals from chiropractors; and, finally, physical therapists do reserve the right on an individual, case-by-case basis to question a referral with the result that the patient may seek treatment elsewhere. Underlying these standards is the basic principle that chiropractors and physical therapists are, in appropriate circumstances, complementary health care providers to the public. Furthermore, the proposed rules are intended to address questions which have frequently been raised before the Boards.

In more specific terms, the jointly proposed rules outline in subsection (a) five items that must be included in writing whenever a chiropractor initiates direction for physical therapy treatment. Besides basic data that identifies the patient and the referring chiropractor, the proposed rules call on the referring chiropractor to describe the purpose of the referral and the spinal component of the patient's problem. As provided for in subsection (b), this information may be supplied verbally so long as it is confirmed in written form within two weeks.

Subsections (c) and (d) require the referring chiropractor and the physical therapist to consult with one another following completion of the physical therapy examination and evaluation so that they may clarify any divergent assessments, coordinate either alternating or concurrent treatment programs, and jointly determine a schedule of additional consultation that will benefit the patient's plan of care. Consultation between the referring chiropractor and the physical therapist should facilitate necessary changes in the program of treatment in cases where either no improvement is forthcoming or the physical therapist believes changes in the treatment program are necessary. Consultation should also permit the physical therapist to become better acquainted with the specifics of a given case and to convey concern should those specifics not strike the physical therapist as appropriate.

In the event the referring chiropractor and the physical therapist do not agree on the appropriate treatment required for a particular patient, the referring chiropractor will seek to place his or her patient with a different physical therapist.

Social Impact

The jointly proposed rules will have a beneficial social impact not only on the public but also on licensees of both Boards. Patients will benefit because the proposed rules create a mechanism by which referring chiropractors and physical therapists will be consulting with one another to resolve whatever questions arise as to the proper programs of treatment. Their interaction will result in post-examination discussions that routinely promise to improve the coordination of the patient's plan of care, and that will result on occasion in greater fine-tuning of monitored, unresponsive courses of chiropractic or physical therapy treatment. These likely benefits are in addition to those offered by the requirement that five written pieces of data are to be furnished with each referral, data that will in itself help to create a standard of accountability and shared information that can only be to the patient's benefit.

Chiropractic licensees should benefit from N.J.A.C. 13:44E-2.14 because the data that covers the purpose of the referral and the spinal component of the patient's problem will create a written record that documents their treatment directions. Furthermore, chiropractic licensees are likely to benefit from this proposed rule because the interaction between referring chiropractors and physical therapists should put them in position to ensure their patients of improvements in the clarity and coordination of treatment programs.

Physical therapist licensees should benefit from N.J.A.C. 13:39A-2.5 because they will be assured of a mechanism governing the referral of patients by chiropractors. Moreover, the proposed rule also benefits physical therapists because it confirms their ability to make professional judgments regarding the patients referred to them. Rather than find themselves in a situation of being forced either to accept or reject a specific regimen of treatment prescribed for a patient by a chiropractor, physical therapists will have the opportunity to offer professional judgments regarding treatment that should lead to productive interaction between physical therapists and chiropractors.

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Economic Impact

The jointly proposed rules will have an economic impact on consumers because they promote greater efficiency in the interaction between referring chiropractors and physical therapists. Fees may be reduced in a number of ways. In those instances where a physical therapist questions or ultimately rejects a program of treatment, that program may be avoided or altered, thereby saving the patient from unnecessary expenses. Furthermore, in cases where the program of treatment is failing to aid the patient, the jointly determined schedule of additional consultation ensures that the physical therapist will be in communication with the referring chiropractor so as to improve or change a program of treatment, thus once again saving the patient from unnecessary fees.

As noted under the Social Impact statement, physical therapists will benefit economically from N.J.A.C. 13:39A-2.5 because the proposed rule puts into place a mechanism that facilitates the referral of patients by chiropractors. The monetary benefits for physical therapists of a solid, working relationship between the two groups of professionals will vary according to the number of specific referrals each physical therapist receives, but the benefit for the profession as a whole is unmistakable and is not tempered by the impact of required consultation for the professional time spent in consultation will be no more than that required in normal practice. The proposed rule will have no economic impact on chiropractors, as it merely facilitates their referral of patients to physical therapists.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., chiropractors and physical therapists are deemed "small businesses" within the meaning of the statute, the following statements are applicable:

N.J.A.C. 13:44E-2.14 will affect all of the approximately 3,000 chiropractors currently licensed by the Board of Chiropractic Examiners, and N.J.A.C. 13:39A-2.5 will affect all of the approximately 3,700 physical therapists currently licensed by the Board of Physical Therapy. The proposed rules require no reporting for either profession. As to recordkeeping, referring chiropractors and physical therapists alike will need to document in the patient record both initial and on-going consultations with members of the opposite profession. In addition, the patient's record will invariably include the basic information required in subsection (a).

The proposed rules will not involve any initial capital costs, any need for acquiring professional services, or any reason for there to be any other foreseeable costs of compliance. Because the intent of the proposed rules is to clarify the professional relationship between chiropractors and physical therapists in regard to referrals, no attempt has been made to create rules that would differentiate based on the size of a licensee's practice in either profession.

Full text of the proposed new rules follows:

13:39A-2.5 Referral of patients by chiropractors

(a) Except as set forth in (b) below, a physical therapist shall not initiate physical therapy treatment unless the physical therapist has received the following information from the referring chiropractor in writing:

1. The name of the patient;
2. The printed name of the referring chiropractor, including office address and phone number;
3. The Signature of the chiropractor and the date;
4. The purpose of referral (for example, "physical therapy examination and treatment"); and
5. The Spinal component of the patient's problem.

(b) A physical therapist may initiate physical therapy treatment based on verbally supplied information provided that the physical therapist ensures that such information is confirmed in written form within two weeks.

(c) After completing the physical therapy examination and evaluation, the physical therapist shall consult with the referring chiropractor. This consultation shall:

1. Clarify any divergent assessments that the referring chiropractor and physical therapist may have made regarding the patient's needs;
2. Coordinate treatment programs in the event that the patient receives concurrent chiropractic and physical therapy. Any such concurrent treatment programs shall be compatible; and
3. Jointly determine a schedule of additional consultation that will allow the physical therapist to monitor the patient's on-going plan of care.

(d) The physical therapist shall document the initial and on-going consultations with the referring chiropractor in the patient's record.

13:44E-2.14 Referral of patients to physical therapists

(a) A chiropractor providing physician direction for the initiation of physical therapy treatment by a physical therapist shall supply the physical therapist with the following information in writing:

1. The name of the patient;
2. The printed name of the referring chiropractor, including office address and phone number;
3. The signature of the chiropractor and the date;
4. The purpose of referral (for example, "physical therapy examination and treatment"); and
5. The spinal component of patient's problem.

(b) The referring chiropractor may verbally supply this information provided that a written confirmation is forwarded to the physical therapist within two weeks.

(c) After the physical therapist has completed the physical therapy examination and evaluation, the referring chiropractor shall participate in consultation with the physical therapist. This consultation shall:

1. Clarify any divergent assessments that the referring chiropractor and physical therapist may have made regarding the patient's needs;
2. Coordinate treatment programs in the event that the patient receives concurrent chiropractic and physical therapy. Any such concurrent treatment programs shall be compatible; and
3. Jointly determine a schedule of additional consultation that will allow the referring chiropractor to monitor the patient's on-going plan of care.

(d) The referring chiropractor shall document the initial and on-going consultations with the physical therapist in the patient's record.

(a)

DIVISION OF CONSUMER AFFAIRS
OFFICE OF CONSUMER PROTECTION
Automotive Dispute Resolution
Proposed Amendments: N.J.A.C. 13:45A-26

Authorized By: Emma N. Byrne, Director, Division of Consumer Affairs.

Authority: N.J.S.A. 56:12-49 and 52:17B-122.

Proposal Number: PRN 1993-501.

Submit written comments by October 7, 1993 to:

Emma N. Byrne
Director
Division of Consumer Affairs
Post Office Box 45027
Newark, New Jersey 07101

The agency proposal follows:

Summary

P.L. 1993, c.21, approved January 22, 1993, made several changes to the Lemon Law, N.J.S.A. 56:12-29 et seq., and also added a new section to Chapter 10 of Title 39, requiring that certain vehicles be permanently identified on their titles as, in effect, "lemons."

Under its new statutory directive, the Division of Motor Vehicles (DMV) must mark the certificate of ownerhsip of any motor vehicle that has been returned to the manufacturer under the New Jersey Lemon Law, under a similar statute of another state, or as the result of a legal action or an informal dispute settlement procedure, before ownership can be transferred or the vehicle resold or released in New Jersey. The "brand" will identify the motor vehicle as having been returned because it did not conform to the manufacturer's warranty and the nonconformity was not corrected within a reasonable time as defined by law.

The "branding" provision and other Lemon Law amendments affected the Division of Consumer Affairs' Lemon Law regulations, thereby necessitating the present proposal.

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Under these proposed amendments, the manufacturer, its agent, or a dealer who accepts a returned vehicle, must stamp the words "MANUFACTURER BUY-BACK NON-CONFORMING VEHICLE" on the face of the original title or other evidence of ownership. Within 10 days, a copy of the stamped document is to be transmitted to the Division of Motor Vehicles (DMV), to indicate that the title is to be permanently branded. Also, the manufacturer must now maintain a record substantiating compliance with N.J.A.C. 13:45A-26.3(a), which mandates that all purchasers or lessees be supplied with a statement on the availability of Lemon Law remedies in case a vehicle is defective. The Notice of Nonconformity, also provided by the manufacturer, now bears a title and a parenthetical explanation of the various proceedings which can result in the return of a motor vehicle to its maker. The Division believes that the title and clarifying passage are needed for full understanding by the consumer of the significance of the mandatory statement.

The manufacturer's responsibilities under N.J.A.C. 13:45A-26.14 are further expanded to include, in its twice-yearly reports to the Division, more information regarding any and all of the manufacturer's informal dispute resolution procedures.

As for dealers and lessors, the proposed amendments detail steps that must be taken before a returned motor vehicle can be resold or released in this State. First, the dealer or lessor must notify the DMV of the sale or lease of the vehicle by forwarding the "branded" title to the DMV for re-issuance to the new owner or lessee. Second, the dealer or lessor must obtain a receipt signed by the customer for the notice of nonconformity. Alternatively, a notation as to receipt of the notice may appear on the sales contract or the lease form. In both cases, mandatory wording is provided.

The present definitions have been slightly changed to update the Lemon Law citation and to define "title." In accordance with statutory changes, the time alloted for review of an Office of Administrative Law decision by the Director of the Division of Consumer Affairs has now been extended from 10 to 15 days. A statement regarding the date of the final decision has been deleted and words substituted that more clearly reflect the New Jersey Court Rule R.2:4-1(b) concerning a party's right to appeal an agency's final decision, and the time limits set forth in that rule.

A new provision has been added at N.J.A.C. 13:45A-26.11(a)3iv to state explicitly, as does the statute, that a prevailing consumer is entitled to fees for expert witnesses, as well as reasonable attorney's fees and costs.

Social Impact

In implementing statutory changes, the proposed amendments follow apparent legislative intent to increase consumer protection against the unwitting purchase or lease of a motor vehicle that had earlier been returned to its manufacturer under the New Jersey Lemon Law or other proceeding. Identification of such vehicles by permanent title-branding, as well as a mandatory receipt to prove that a potential buyer or lessee has received notice of noncomformity, make it unlikely that such vehicles can be profitably sold or leased in New Jersey. At the very least, disclosure of the car's status will have been made to a prospective customer, to his or her obvious benefit. It should be noted that evidence, in the form of a signed receipt, also protects the dealer by eliminating the possible accusation of non-disclosure.

The new requirement of a record substantiating the fact that the manufacturer has supplied the mandatory statements regarding the availability of Lemon Law remedies, N.J.A.C. 13:45A-26.3(a), will give the Division of Consumer Affairs an enforcement tool. The new requirement will simultaneously protect the manufacturer against any claims by its dealers or lessors that such statements were never given to them.

The changes in time limits for various mandated actions benefit the Division of Consumer Affairs and manufacturers. The previous limit of 10 days for review of an OAL decision, which must be painstaking and thoughtful, placed inordinate stress upon the Division. That is now relieved by the allotment of an additional five days.

Finally, additional details on informal dispute settelement procedures will aid the Division and consumers by further clarifying the workings and settlement record of such programs. This information is needed in order for the Lemon Law Unit to prepare a thorough report, as it is required to do under the Lemon Law. The report is made available to the public every six months. It provides the public with the ability to compare the record of manufacturers and, armed with that data, to make a more informed choice when buying or leasing a motor vehicle.

Economic Impact

The proposed amendments will have an adverse economic effect on dealers, lessors, and manufacturers of motor vehicles that are returned to the manufacturer under the New Jersey Lemon Law, under a similar statute of another state, or as the result of a legal action or an informal dispute settlement procedure. Such a motor vehicle cannot be resold, released, or the title transferred in this State unless specific procedures are followed. These steps now include, for the manufacturer, sending the title to the DMV for "branding," a task which may require some recordkeeping expense, albeit minimal. Furthermore, the manufacturer will bear the added cost of maintaining a record that documents its supplying of statements about Lemon Law remedies to its dealers and lessors, and will also have the expense of preparing and remitting, on a regular basis, the additional information required under N.J.A.C. 13:45A-26.14(c)1 and 2.

For the dealer or lessor, some expense in terms of staff time will be incurred as a result of preparing and obtaining a signed receipt for the non-conformity disclosure.

Overall economic loss may be sustained by the manufacturer, dealer or lessor, by virtue of the tighter rules regarding disclosure to consumers—by receipted notice as well as on the branded title—of the fact that a particular motor vehicle was returned for non-conformity with the warranty and failure to repair the defect during the time specified by law.

On the other hand, consumers will enjoy decided economic benefit. Having been fully informed, they are likely either not to buy or lease a recycled "lemon," with its potential for future repair expense, or alternatively they should be able to acquire the vehicle for less money than might otherwise be charged. In any case, an unwitting purchase or lease of a "lemon" will be avoided. The permanently branded title, as well as the receipt disclosure, will in fact afford valuable protection to the pocketbooks of all future purchasers and lessees.

Regulatory Flexibility Analysis

The proposed amendments will impact upon an unknown but very large number of new and used car dealers, as well as dozens of manufacturers of motor vehicles in this country and abroad. It is probable that many of the dealers, particularly in the used car field, would be classfied as small businesses under the definition in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. While neither the services of other professional nor capital investment are needed for compliance with these regulations, the proposed amendments do entail both reporting and recordkeeping by the dealers and lessors, undoubtedly creating some expense in terms of staff time. However, the rules mirror statutory requirements and therefore cannot be changed for small businesses, nor can any small business be exempted. The Division of Consumer Affairs believes that the burden on small businesses is both reasonable and greatly outweighed by the benefits to consumers.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:45A-26.2 Definitions

As used in this subchapter, the following words shall have the following meanings:

. . .

"Lemon Law" means P.L. 1988, c.123, an Act concerning new motor warranties and repealing P.L. 1983, c.215, **as amended by P.L. 1993, c.21**.

. . .

"Title" means the certificate of ownership of a motor vehicle.

13:45A-26.3 Statements to consumer; **other notices**

(a) At the time of purchase or lease of a motor vehicle in the State of New Jersey, the manufacturer, through its dealer or lessor, shall provide the following written statement directly to the consumer on a separate piece of paper, in 10-point boldface type:

"IMPORTANT: IF THIS VEHICLE IS DEFECTIVE, YOU MAY BE ENTITLED UNDER NEW JERSEY LAW TO A REFUND OF THE PURCHASE PRICE OR YOUR LEASE PAYMENTS. FOR COMPLETE INFORMATION REGARDING YOUR RIGHTS AND REMEDIES UNDER THE RELEVANT LAW, CONTACT THE NEW JERSEY DEPARTMENT OF LAW AND PUBLIC SAFETY, DIVISION OF CONSUMER AFFAIRS,

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LEMON LAW UNIT, AT POST OFFICE BOX 45026, 124 HALSEY STREET, NEWARK, NEW JERSEY 07102, TEL. NO. (201) 504-6226.

The manufacturer, through its dealer or lessor, shall maintain a record substantiating compliance with this section and shall make the record available to the Division upon request.

(b) If a motor vehicle is returned to the manufacturer under the provisions of the Lemon Law or a similar statute of another state or as the result of a legal action or an informal dispute settlement procedure, the motor vehicle shall not be resold or released in New Jersey unless the **following steps are taken:**

1. Immediately upon receipt of the vehicle, the manufacturer, its agent, or a dealer who accepts the vehicle shall cause the words "R—RETURNED TO MANUFACTURER UNDER LEMON LAW OR OTHER PROCEEDING" to be clearly and conspicuously stamped on the face of the original certificate of title, the manufacturer's statement of origin, or other evidence of ownership.

2. Within 10 days of receipt of the vehicle, the manufacturer, its agent, or a dealer who accepts the vehicle shall submit a copy of the stamped document to the Special Title Section of the Division of Motor Vehicles to indicate that title to the vehicle shall be permanently branded.

3. The manufacturer **shall** provide[s] to the dealer or lessor, and the dealer or lessor **shall** provide[s] to the consumer prior to the resale or re-lease of the motor vehicle **a copy for the consumer's records of** the following statement on a separate piece of paper, in 10-point boldface type:

NOTICE OF NONCONFORMITY

"IMPORTANT: THIS VEHICLE WAS RETURNED TO THE MANUFACTURER BECAUSE IT DID NOT CONFORM TO THE MANUFACTUER'S WARRANTY AND THE NONCONFORMITY WAS NOT CORRECTED WITHIN A REASONABLE TIME AS PROVIDED BY LAW."

(This notice is required under the New Jersey "Lemon Law", N.J.S.A. 56:12-1 et seq., for vehicles that have been replaced or repurchased by the manufacturer as the result of any one of the following: a court judgment, or a final decision pursuant to a hearing or settlement by the Office of Administrative Law, or an arbitration proceeding between the manufacturer or its agent and a consumer.)

4. Upon delivery to the consumer of the statement in (b)3 above the dealer or lessor shall obtain from the consumer a signed receipt, on a separate sheet of paper, which shall state the following, in underlined 10-point boldface type:

"I ACKNOWLEDGE RECEIPT OF NOTICE OF NONCONFORMITY OF THIS VEHICLE, VIN NO. _____ AS REQUIRED BY N.J.S.A. 56:12-35 (THE 'LEMON LAW')."

Alternatively, the dealer or lessor may fulfill this requirement by making the following notation in underlined boldface type on the front page of the vehicle buyer order form or the lease form:

"NOTICE OF NONCONFORMITY OF THIS VEHICLE, VIN NO. _____, HAS BEEN PROVIDED TO THE PURCHASER OR LESSEE, AS REQUIRED BY N.J.S.A. 56:12-35 (THE 'LEMON LAW')."

5. The manufacturer, dealer or lesSor shall notify the Special Title Section of the Division of Motor Vehicles of the resale or release of the vehicle by requesting transfer of the branded title to the new owner or lessor, in writing.

(c)-(D) (No change.)

13:45A-26.4 Lemon Law Unit

(a)-(b) (No change.)

(c) All correspondence by consumers or manufacturers to the Division of Consumer Affairs regarding Lemon Law matters shall be directed to the attention of the Lemon Law Unit, as follows:

Division of Consumer Affairs
Lemon Law Unit
P.O. Box 45026, **124 Halsey Street**
Newark, New Jersey 07101
Telephone (201) 504-6226

13:45A-26.11 Computation of refund

(a) The refund claimed by a consumer pursuant to section 4(a) of the Lemon Law, whether through the Division of Consumer Affairs automotive dispute resolution system or a manufacturer's informal dispute resolution process, shall include:

1.-2. (No change.)

3. Other charges or fees, including but not limited to:

i. Reimbursement for towing, if any;

ii. Reimbursement for actual expenses incurred by the consumer for the rental of a motor vehicle equivalent to the consumer's motor-vehicle was out of service due to a nonconformity; [and]

iii. Filing fee for participation in the Division's dispute resolution system[.]; **and**

iv. Reimbursement for reasonable attorney's fees, fees for reports prepared by expert witnesses, and costs.

13:45A-26.12 Final decision

(a) The Director shall review the OAL proposed decision submitted by the administrative law judge who conducts the administrative hearing and shall adopt, reject, or modify the decision no later than [10] **15** days after receipt.

(b) At the conclusion of the **15-day** review period, the Director shall mail notification of the rejected, modified or adopted decision to both parties, the lien-holder, if any, [and to] the OAL**, and, if the vehicle in question is to be returned to the manufacturer, the Special Title Section of the DMV**. The mailing to the manufacturer and consumer shall be by certified mail, return receipt requested. [The date of the mailing shall be deemed the date of the final decision.] **Within 45 days of receipt of the final decision, any party may file an appeal in the Appellate Division of the Superior Court.**

(c)-(d) (No change.)

13:45A-26.14 Manufacturer's informal dispute resolution procedures

(a)-(b) (No change.)

(c) On [the 15th of] January [1990] **15** and [on every 15th of] July **15 of every year** [and 15th of January thereafter], the LLU shall mail a questionnaire by certified mail, return receipt requested, to every manufacturer on the roster compiled pursuant to (a) above, requesting the following information:

1. Any and all informal dispute settlement procedures utilized by the manufacturer. If the informal dispute settlement procedure is an in-house customer assistance mechanism or private arbitration or private buy-back program instituted by the manufacturer, the information provided shall include the reasons for establishing and maintainng such programs.

[1.]**2.** The number of purchase price and lease price refunds requested, the number awarded by [the] **any** dispute settlement body **or other settlement procedure identified in (c)1 above**, the amount of each award and the number of awards satisfied in a timely manner.

Recodify existing 2.-4. as **3.-5.** (No change in text.)

(d) (No change.)

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TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits

Routes U.S. 40, U.S. 40 and U.S. 322, and N.J. 87 in Atlantic County

Proposed Amendments: N.J.A.C. 16:28-1.6, 1.56 and 1.111

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.

Proposal Number: PRN 1993-460.

Submit comments by October 7, 1993 to:
Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28-1.6, 1.56 and 1.111 to establish revised "speed limit" zones along Routes U.S. 40 in the Townships of Buena Vista and Hamilton, Atlantic County; U.S. 40/U.S. 322 in Hamilton Township, Atlantic County; and N.J. 87 in the Cities of Atlantic City and Brigantine, Atlantic County. The provisions of these rules will improve the flow of traffic and enhance safety along the highway system.

These amendments are being proposed at the request of the Township of Hamilton and the Cities of Atlantic City and Brigantine. The Township of Hamilton in its request asked that the speed limit on Route 40 between mile markers 45 and 47 be reduced from 50 miles per hour to a maximum of 40 miles per hour. The Cities of Brigantine and Atlantic City in their request asked that the speed limit on the Route 87 bridge be lowered from 50 miles per hour to 45 miles per hour to be consistent with the currently posted speed limits on either side of the bridge.

The Department's Bureau of Traffic Engineering and Safety Programs evaluated these requests and conducted investigations. The Department's review proved that the establishment of the lower speed limit zones along Routes U.S. 40, U.S. 40/U.S. 322, and N.J. 87 in Atlantic County were warranted. However, the speed limit on Route 40 between mile markers 45 and 47 was established at 45 miles per hour. Additionally, the speed limits along Route U.S. 40 in the Townships of Buena Vista and Hamilton, Atlantic County and U.S. 40/U.S. 322 in Atlantic County, were established prior to the enactment of the Administrative Code, and are now being codified in the Administrative Code to conform to existing mileposts. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendments will establish revised "speed limit" zones along Route U.S. 40; U.S. 40/U.S. 322 in Hamilton Township, Atlantic County; and N.J. 87 in the Cities of Atlantic City and Brigantine, Atlantic County for the efficient flow of traffic, and the enhancement of safety along the highway system. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of the "speed limit" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendments do not place any reporting, recordkeeping or compliance requirements on small busineses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments primarily affect the motoring public and the govermental entities responsible for the enforcement of the rules.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

16:28-1.6 Route U.S. 40[1]

(a) The rate of speed designated for the certain parts of State highway Route U.S. 40 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic:

i.-ii. (No change.)

iii. In Atlantic County;

(1) (No change.)

(2) Buena Vista Township:

(A)-(C) (No change.)

(D) Zone 4: 50 miles per hour between Holly Avenue and the Buena Vista Township-Hamilton Township line (approximate mileposts 38.62 to [39.14] **39.15**); **thence**

(3) Hamilton Township:

(A) Zone 1: 50 miles per hour between the Hamilton Township-Buena Vista Township line and 350 feet west of Essex Avenue (approximate mileposts 39.15 to 44.95); thence

(B) Zone 2: 45 miles per hour between 350 feet west of Essex Avenue and 500 feet east of Walkers Forge Road (approximate mileposts 44.95 to 45.63); thence

(C) Zone 3: 50 miles per hour between 500 feet east of Walkers Forge Road and 500 feet west of Route N.J. 50 (approximate mileposts 45.63 to 46.25); thence

(D) Zone 4: 40 miles per hour between 500 feet west of Route N.J. 50 and 200 feet west of Taylor Road (approximate mileposts 46.25 to 46.73); thence

(E) Zone 5: 30 miles per hour between 200 feet west of Taylor Road and County Road 617 Connector Road (approximate mileposts 46.73 to 47.29); thence

(F) Zone 6: 40 miles per hour between County Road 617 Connector Road and 400 feet east of Old Egg Harbor Road (approximate mileposts 47.29 to 47.48); thence

(G) Zone 7: 50 miles per hour between 400 feet east of Old Egg Harbor Road and the Route U.S. 322-Route U.S. 40 junction (approximate mileposts 47.48 to 51.71).

[1]See also N.J.A.C. 16:28-1.56 and 1.118

16:28-1.56 Route U.S. 40 and U.S. 322

(a) The rate of speed designated for the certain parts of State highway U.S. 40 and U.S. 322 described in this subsection shall be established and adopted as the maximum legal rate of speed[.]**:**

1. For both directions of traffic:

i. In Atlantic County:

(1) Hamilton Township:

(A) Zone 8: 55 miles per hour between the Route U.S. 322-Route U.S. 40 Junction and the Egg Harbor Township-Hamilton Township Line (approximate mileposts 51.71 to 53.15); thence

Recodify existing (1)-(4) as **(2)-(5)** (No change in text.)

16:28-1.111 Route 87

(a) The rate of speed designated for the certain parts of State highway Route 87 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic in the Cities of Atlantic City[,] **and** Brigantine, Atlantic County:

[i. Zone one: 45 mph between Route U.S. 30-Illinois Avenue and 2,100 feet north of Huron Avenue-Brigantine Boulevard (Route N.J. 187) mileposts 0.0 to 1.02); thence

ii. Zone two: 50 mph between 2,100 feet north of Huron Avenue-Brigantine Boulevard (Route N.J. 187) and the end of the New Jersey Department of Transportation jurisdiction (mileposts 1.02 to 1.72).]

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i. 45 miles per hour between Route U.S. 30 and the end of the New Jersey Department of Transportation jurisdiction (approximate mileposts 0.0 to 1.72.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route N.J. 28 in Somerset County
Proposed Amendment: N.J.A.C. 16:28A-1.19

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-198.

Proposal Number: PRN 1993-478.

Submit comments by October 7, 1993 to:
Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28A-1.19 to establish the following parking restrictions along Route N.J. 28 in the Borough of Bound Brook, Somerset County: no stopping or standing zones; no parking bus stop zones; and no parking certain hours zones.

The provisions of these amendments will improve the flow of traffic and enhance safety along the highway system.

These amendments are being proposed at the recommendation of the Chief of Police to the Borough Council of Bound Brook, which adopted the following Resolutions on May 11, 1993 requesting that the Department approve the parking restrictions outlined: Resolution No. 93-57, no stopping or standing prohibited at all times on certain streets; Resolution No. 93-59, bus stops, no vehicle other than an omnibus, picking up or discharging passengers, shall be permitted to occupy said location between the hours indicated; and Resolution No. 93-60, parking prohibited during certain hours on school days on certain streets.

Based upon the request from the local government, in the interest of safety, and as part of the ongoing review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation proved that the establishment of "no stopping or standing," "no parking bus stops" and "no parking certain hours" zones along Route N.J. 28 in the Borough of Bound Brook were warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendments will establish "no stopping or standing," "no parking bus stop" and "no parking certain hours" parking restrictions along Route N.J. 28 in the Borough of Bound Brook, Somerset County, to improve traffic flow and enhance safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The local government will bear the costs for the installation of appropriate parking restriction zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size and method of procurement. Motorists who violate the rules will be assessed the appropriate fines in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendments do not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments primarily affect the motoring public and the governmental entities responsible for the enforcement of the rule.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

16:28A-1.19 Route 28

(a) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1.-6. (No change.)

7. No stopping or standing in the Borough of Bound Brook, Somerset County:

[i. Along the northerly (westbound) side:

(1) Between the Borough of Middlesex-Borough of Bound Brook corporate line and a point 110 feet west of the prolongation of the westerly curb line of East Street;

(2) Between the intersection of Windsor Street and a point 350 feet westerly therefrom;

(3) Between the easterly curb line of Washington Street to a point 300 feet easterly therefrom;

(4) Between a point 200 feet east of the easterly curb line of Thompson Avenue and a point 120 feet west of the westerly curb line of Thompson Avenue;

(5) Between a point 370 feet west of the westerly curb line of Thompson Avenue and the Bound Brook Borough-Bridgewater Township Corporate line;

(6) From a point 145 feet west of the westerly curb line of Clearview Place to a point 50 feet of the westerly curb line of Thompson Avenue;

(7) From a point 270 feet west of the westerly curb line of Thompson Avenue to the Borough of Bound Brook-Township of Bridgewater corporate line;

(8) From the westerly curb line of Highland Place to a point 114 feet westerly therefrom.

ii. Along the southerly (eastbound) side:

(1) Between the intersection of Windsor Street and a point 40 feet easterly therefrom;

(2) Between a point 900 feet east of the easterly curb line of Vosseler Avenue and a point 300 feet west of the westerly curb line of Vosseler Avenue.

(3) Between a point 200 feet east of the easterly curb line of Thompson Avenue and the Bound Brook Borough-Bridgewater Township Corporate line;

(4) From the Township of Bridgewater-Borough of Bound Brook corporate line and a point 122 feet east of the easterly curb line of Thompson Avenue;

(5) From the westerly curb line of Vosseler Avenue to a point 282 feet westerly therefrom;

(6) From East Street to the Borough of Bound Brook-Borough of Middlesex corporate line;

(7) From a point 40 feet east of the easterly curb line of Highland Place to a point 72 feet west of the westerly curb line of Highland Place.]

i. Along the northerly (westbound) side (Union Avenue):

(1) Between the Borough of Middlesex-Borough of Bound Brook corporate line and a point 110 feet west of the prolongation of the westerly curb line of East Street;

(2) From the easterly curb line of Church Street to a point 86 feet easterly therefrom;

(3) From the westerly curb line of Church Street to a point 86 feet westerly therefrom;

(4) From the easterly curb line of Livingston Street to a point 85 feet easterly therefrom;

(5) From the westerly curb line of Livingston Street to a point 85 feet westerly therefrom;

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(6) From a point 270 feet west of the westerly curb line of Thompson Avenue to the Borough of Bound Brook-Township of Bridgewater corporate line.

ii. Along the southerly (eastbound) side (Union Avenue):

(1) From the Township of Bridgewater-Borough of Bound Brook corporate line to a point 122 feet east of the easterly curb line of Thompson Avenue;

(2) From the westerly curb line of Vosseller Avenue to a point 282 feet westerly therefrom;

(3) From the westerly curb line of Livingston Street to a point 85 feet westerly therefrom;

(4) From the easterly curb line of Livingston Street to a point 85 feet easterly therefrom;

(5) From the westerly curb line of Church Street to a point 86 feet westerly therefrom;

(6) From the easterly curb line of Church Street to a point 86 feet easterly therefrom;

(7) From the easterly curb line of East Street to the Borough of Bound Brook-Borough of Middlesex corporate line.

8.-13. (No change.)

(b) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no parking bus stop" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1.-16. (No change.)

17. In the Borough of Bound Brook, Somerset County:

i. Along the eastbound (southerly) side (Union Avenue):

(1) Near side bus stops:

(A) Tea Street—Beginning at a point 35 feet from the westerly curb line of Tea Street and extending 70 feet westerly therefrom;

(B) Thompson Avenue—Beginning at a point 35 feet from the westerly curb line of Thompson Avenue and extending 70 feet westerly therefrom;

(C) Washington Street—Beginning at a point 35 feet west of the prolongation of the westerly curb line of Washington Street and extending 70 feet westerly therefrom;

(D) Windsor Street—Beginning at a point 35 feet from the westerly curb line of Windsor Street and extending 70 feet westerly therefrom;

(E) Mountain Avenue—Beginning at a point 35 feet from the westerly curb line of Mountain Avenue and extending 70 feet westerly therefrom.

(2) Far side bus stops:

(A) East Street—Beginning at a point 35 feet east of the easterly curb line of East Street and extending 65 feet easterly therefrom.

ii. Along the westbound (northerly) side (Union Avenue):

(1) Near side bus stops:

(A) Mountain Avenue—Beginning at a point 35 feet from the easterly curb line of Mountain Avenue and extending 70 feet easterly therefrom;

(B) Washington Street—Beginning at a point 35 feet from the easterly curb line of Washington Street and extending 70 feet easterly therefrom;

(C) Tea Street—Beginning at a point 35 feet east of the easterly curb line of Tea Street and extending 70 feet easterly therefrom.

(2) Far side bus stops:

(A) Windsor Street—Beginning at a point 35 feet west of the prolongation of the westerly curb line of Windsor Street and extending 70 feet westerly therefrom;

(B) Thompson Avenue—Beginning at a point 35 feet west of the westerly curb line of Thompson Avenue and extending 65 feet westerly therefrom.

(c)-(f) (No change.)

(g) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no parking during certain hours" zones. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following "no parking during certain hours" zones:

1. (No change.)

2. In the Borough of Bound Brook, Somerset County:

i. Along the northerly (westbound) side (Union Avenue):

(1) Beginning at a point 105 feet west of the prolongation of the westerly curb line of Windsor Street to a point 225 feet westerly therefrom from 8:00 A.M. to 4:00 P.M. on school days.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Notice of Administrative Correction
Restricted Parking and Stopping
Time Limit Parking on Route N.J. 77 in the City of Bridgeton, Cumberland County

Proposed Amendment: N.J.A.C. 16:28A-1.41 (f)1ii(1)(B)

Take notice that the Department of Transportation has discovered an error in the text of the proposed amendment to N.J.A.C. 16:28A-1.41(f)1ii(1)(B) published in the June 21, 1993 New Jersey Register at 25 N.J.R. 2649(a). The notice of proposal filed with the Office of Administrative Law (see PRN 1993-327) and published reflected that N.J.A.C. 16:28A-1.41(f)1ii(1)(B) reads, "Beginning at a point 124.95 feet south of the southerly curb line of East Commerce Street and extending 22.00 feet south therefrom." The subparagraph should have read, "Beginning at a point **142.95** feet . . ." The figures were transposed, as discovered upon review by Department staff.

The Department therefore extends the comment period on said proposed subparagraph (f)1ii(1)(B) to October 7, 1993, to permit any interested person to discern from that subparagraph where the restricted space proposed by the Department began.

This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7 to correct any confusion that may have arisen due to the error in the text of the proposed amendment.

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route N.J. 77 in Cumberland County

Proposed Amendment: N.J.A.C. 16:28A-1.41

Authorized By: Richard C. Dube, Director, Division of Traffic Engineer and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-199.

Proposal Number: PRN 1993-403.

Submit comments by October 7, 1993 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28A-1.41 to establish "no parking certain hours" zones along Route N.J. 77 in the City of Bridgeton, Cumberland County. This amendment is being proposed at the request of the City of Bridgeton that no parking be allowed between 2:00 A.M. and 6:00 A.M., Monday through Saturday, to allow for street cleaning along the southbound and northbound sides of N.J. Route 77. The traffic investigation conducted by the Department's Bureau of Traffic Engineering and Safety Programs proved that the

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establishment of no parking zones during certain hours in the City of Bridgeton, Cumberland County, were warranted. Appropriate signs will be erected to advise motorists.

Social Impact

The proposed amendment will establish "no parking certain hours" along Route N.J. 77 in the City of Bridgeton, Cumberland County for the efficient flow of traffic, the enhancement of safety and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local governments will incur direct and indirect costs for mileage, personnel and equipment requirements. The City of Bridgeton will pay for the installation of signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendment does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

Full text of the proposal follows (additions indicated in boldface **thus**):

16:28A-1.41 Route 77

(a)-(d) (No change.)

(e) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "no parking certain hours" zones. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following zones:

1. No parking certain hours in Cumberland County:

i. In the City of Bridgeton:

(1)-(2) (No change.)

(3) Along the southbound (west side) for street cleaning from 2:00 A.M. to 6:00 A.M. Monday through Saturday:

(A) Beginning at a point 108.57 feet south of the southerly curb line of Washington Street to a point 305.57 feet south of the southerly curb line of Washington Street.

(B) Beginning at a point 40.70 feet south of the southerly curb line of Church Lane to a point 115.70 feet south of the southerly curb line of Church Lane.

(C) Beginning at a point 142.95 feet south of the southerly curb line of East Commerce Street to a point 309.95 feet south of the southerly curb line of East Commerce Street.

(4) Along the northbound (east side) for street cleaning from 2:00 A.M. to 6:00 A.M. Monday through Saturday:

(A) Beginning at a point 105.00 feet north of the northerly curb line of Route N.J. 49 to a point 180.00 feet north of the northerly curb line of Route N.J. 49.

(B) Beginning at a point 35.77 feet south of the southerly curb line of McCormick Place to a point 108.77 feet south of the southerly curb line of McCormick Place.

(C) Beginning at a point 90.00 feet north of the northerly curb line of McCormick Place to a point 164.40 feet north of the northerly curb line of McCormick Place.

(D) Beginning at a point 100.00 feet north of the northerly curb line of East Commerce Street to a point 167.00 feet north of the northerly curb line of East Commerce Street.

(E) Beginning at a point 261.00 feet north of the northerly curb line of East Commerce Street to a point 444.00 feet north of the northerly curb line of East Commerce Street.

(f) (No change.)

(a)

DIVISION OF TRANSPORTATION SYSTEMS PLANNING
BUREAU OF AUTHORITY COORDINATION AND LOCAL TRANSPORTATION PLANNING

State Highway Access Management Code Access Classifications

Proposed Amendment: N.J.A.C. 16:47-8.5

Authorized By: Kathy A. Stanwick, Deputy Commissioner, Department of Transportation.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:7-44.1 and State Highway Access Management Act, P.L.1989, c.32.

Proposal Number: PRN 1993-489.

Submit comments by October 7, 1993 to:
Charles L. Meyers
Administrative Practice Officer
New Jersey Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625
(609) 530-5720

The agency proposal follows:

Summary

On April 20, 1992, the New Jersey Department of Transportation adopted new rules at N.J.A.C. 16:47 to implement the provision of the State Highway Management Act, P.L.1989, c.32 (N.J.S.A. 27:7-91 et seq.).

On March 24, and 25, 1993, the New Jersey Department of Transportation conducted training sessions with county planners and county engineers to facilitate dialogues concerning access classifications between the municipalities, counties, and the Department. Based on input from those meetings, several county representatives requested that the time frame for county input given under N.J.A.C. 16:47-8.5, Access Classifications, be extended.

The proposed amendment extends the date as requested by the county representatives. The date will be extended to allow county input until September 21, 1994. Furthermore, the New Jersey Department of Transportation will assist the counties in this effort.

Social Impact

The proposed amendment will enable the county representatives to solicit input and help build consensus with the municipalities. The Department will realize significant benefit by communicating the need to balance mobility and development consequences and foster a regional review of transportation impacts. Coordination of long term Department plans with the local master plan and zoning processes will help maintain safe and efficient mobility on State highways and encourage the efficient use of limited public and natural resources.

Because the Access Code in accordance with N.J.A.C. 16:47-5 allows for formal petition for an access classification change on a specific highway segment, no adverse social impacts are anticipated to result from extending the time frame for county input.

Economic Impact

The proposed amendment does not economically impact the general public. There are no changes in permit fees, nor in the requirements for compliance with the Access Code.

Regulatory Flexibility Analysis

The proposed amendment will not change the requirements for any business, some of whom may be considered small businesses, as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The change may be beneficial to the regulated public by allowing the county representatives additional time to prepare comments, resolve potential conflicts between municipalities, and organize and submit this information to the Department.

Also, any small business and any individual will continue to be allowed to propose changes to the access classification system in accordance with N.J.A.C. 16:47-5.

Full text of the proposal follows (additions indicated in boldface **thus;** deletions indicated in brackets [thus]):

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16:47-8.5 Access classifications

(a) (No change.)

(b) [Within one year of the adoption of this Access Code, each] **Each** county may recommend revisions to the access classifications and desirable typical sections of each State highway segment within the county boundaries **by September 21, 1994**. The Department shall make those revisions it determines to be warranted and adopt the changes in accordance with N.J.A.C. 16:47-5.5(c).

TREASURY-GENERAL

(a)

DIVISION OF PENSIONS AND BENEFITS

Consolidated Police and Firemen's Pension Fund

Proposed Readoption with Amendments: N.J.A.C. 17:6

Authorized By: Consolidated Police and Firemen's Pension Fund Commission, Wendy Jamison, Secretary.

Authority: N.J.S.A. 43:16-7.

Proposal Number: PRN 1993-461.

Submit comments by October 7, 1993, to:
Peter J. Gorman, Esq.
Administrative Practice Officer
Division of Pensions and Benefits
CN 295
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Division of Pensions and Benefits and the Consolidated Police and Firemen's Pension Fund Commission is constantly reviewing the administrative rules within N.J.A.C. 17:6 concerning the Consolidated Police and Firemen's Pension Fund. When the Division becomes aware of a change in the laws or a court decision that possibly could affect the Fund, the administrative rules are reviewed and, if changes therein are mandated, steps are taken to propose changes to those rules to conform to the new statute or court decision. Additionally, the rules are periodically reviewed by the Division's staff to ascertain if the current rules are necessary and/or cost efficient. After careful scrutiny of the current rules in N.J.A.C. 17:6, the Division is satisfied that the majority of such rules are necessary and needed for the efficient operation of the Fund. Accordingly, the Consolidated Police and Firemen's Pension Fund proposes to readopt the current rules within N.J.A.C. 17:6, which are set to expire November 22, 1993. The rules govern Fund administration (Commission meetings, officers and committees; records; decision appeals, etc.), Fund membership, the retirement process and interfund transfers.

In addition to the proposed readoption of the current rules within N.J.A.C. 17:6, the Commission is proposing to amend two of its rules concerning quorums. The proposed amendments involve changing the number of members of the Commission necessary to constitute a quorum from five to four members. There are several vacancies on the Commission and it does not appear that such vacancies will be filled in the near future. Thus, it is oftentimes difficult to have a quorum present in order to conduct business at the Commission's meetings. Also, due to the distances such members must travel and health problems experienced by some of the members, it was felt that, with proper notice being given and adequate opportunity to be heard by the public, a member could participate in the conduct of the Commission's business at its meeting via telecommunications' connections rather than by actual personal appearances at the meeting.

Finally, there are minor amendments proposed to reflect changes in the name of specified organizations and gender changes to include both male and female individuals.

Social Impact

The rules involving the Consolidated Police and Firemen's Pension Fund affect and work to the benefit of past and present public employees who have or are participating in the Consolidated Police and Firemen's Pension Fund. The taxpaying public is affected by these rules in the sense that public monies are used to fund the benefits. No social impact is anticipated from the amendments.

Economic Impact

While the readoption of the rules and the proposed amendments will not present any adverse economic impact to the public, the payment of the benefits and claims mandated in the statutes are funded by public employer contributions and thus indirectly by taxpayers. If the administrative rules are not readopted, the benefits and claims mandated by the statutes must still be paid. Without the administrative rules to provide for the efficient operation of the Consolidated Police and Firemen's Pension Fund, chaos would occur.

Regulatory Flexibility Statement

The rules of the Consolidated Police and Firemen's Pension Fund only affect public employers and employees. Thus, this proposed readoption does not impose any reporting, recordkeeping or other compliance requirements upon small businesses. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 17:6.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

17:6-1.1 Commission meetings

(a) The commission shall meet on the second Wednesday of each month, unless a change is declared in order by the chairman at an appropriate time, and subject to the exception of the annual meeting prescribed by N.J.S.A. 43:16-6.2.

(b) The presence of four commission members at the start of any meeting of the commission will be necessary in order to constitute a quorum of the commission. Such presence need not be actual physical presence but may, at the determination of the chairman that the circumstances warrant it, include the participation of any of the four commission members by telecommunications' connection.

17:6-1.3 Officers and committees

(a) The chairman of the commission will be elected by a majority vote of the members in attendance at the first meeting of each fiscal year, not less than [five] **four** members to be present at such a meeting. The chairman of the board shall preside at all meetings he **or she** attends and in his **or her** absence another member selected by the majority of the members in attendance will preside for that single meeting.

(b) Upon recommendation of the [Chief of the Bureau of Police and Fire Funds] **Director of the Division of Pensions and Benefits**, the commission will select from the staff of such [Bureau] **Division** a secretary and assistant secretary, the latter to serve in the absence of the secretary.

(c) The chairman will appoint such committees from the commission members as he **or she** deems necessary to facilitate the commission's operations. Such committee appointments will be for a one-year period, commencing each July 1.

OTHER AGENCIES

(b)

HACKENSACK MEADOWLANDS DEVELOPMENT COMMISSION

Administration

Disability Discrimination Grievance Procedure

Proposed New Rules: N.J.A.C. 19:3A-3

Authorized By: Hackensack Meadowlands Development Commission, Anthony Scardino, Jr., Executive Director.

Authority: N.J.S.A. 13:17-1 et seq., 42 U.S.C. 12101 et seq., and 28 C.F.R. 35.107.

Proposal Number: PRN 1993-479.

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Submit written comments by October 7, 1993 to:
Edward Bulmer, ADA Coordinator
Hackensack Meadowlands Development Commission
One DeKorte Park Plaza
Lyndhurst, New Jersey 07071

The agency proposal follows:

Summary

The proposed rules establish a procedure for the Hackensack Meadowlands Development Commission (HMDC) to follow when someone wishes to complain that the HMDC has done something that violates the Americans with Disabilities Act, also known as the ADA (42 U.S.C.A. §12101 et seq.). The ADA prohibits a public entity, including the HMDC proposing to adopt these rules, from discriminating against a qualified individual with a disability, or from excluding that person from participation in, or denying the person the benefits of, the services, programs or activities of the agency. Regulations of the United States Justice Department (found at 28 C.F.R. Part 35) require that such governmental agencies maintain and publish a procedure to be followed when someone wishes to complain of a violation of the law. Under this procedure anyone, including an employee or applicant for employment, who believes he or she has been discriminated against in any program, service or activity of the HMDC, may require the HMDC to review and, if appropriate, to investigate the grievance. These rules set a 45-day objective for the completion of the inquiry by the HMDC and the issuance of a written determination by the HMDC or a designee; they also set a 20-day limit following the incident complained of in which the individual may file the grievance. The rules also identify by title, with address and telephone number, the ADA coordinator of the HMDC who will be the person to receive the grievances in the first instance. These rules will also contain a form for filing a grievance and a Notice of ADA Procedure, a copy of which will be made available to interested persons.

Social Impact

Because the injustice of discrimination continues to be visited upon the disabled members of our society solely on account of their disabilities, Congress passed the ADA, which attacks that injustice on many fronts and with many methods. One of these fronts is public entities and one of the methods is the requirement that such public entities undertake an examination of complaints that they have violated the substantive provisions of the ADA. The disabled are sometimes excluded from the programs, services or activities of government agencies out of ignorance on the part of the non-disabled and sometimes out of the lack of an available established mechanism whereby those barriers to participation or enjoyment of benefits can be removed. This proposed grievance procedure will provide the disabled one means to correct such lingering discrimination and to eliminate persisting barriers. The procedure will also assist HMDC to eliminate such discrimination by bringing to the agency's attention instances where such discrimination continues to exist and providing the agency the necessary insight and opportunity to correct them. Both the society at large, the HMDC in particular, and the disabled individuals will benefit from the enactment of these rules, as barriers to access are removed and the programs, services and activities of the HMDC are made available in a nondiscriminatory manner, thereby enabling the disabled fuller and more equal participation in all aspects of life. It is in the nature of the proposed procedure that it be informal and expeditious, but still effective; thus, the remediation of discriminatory conditions will be facilitated quickly and without the cumbersome and sometimes counterproductive formalities of other methods of complaint resolution.

Economic Impact

Although the proposed grievance procedure will result in some minor additional expense to the HMDC, the result of the inquiries and investigations precipitated by the use of the procedure may have significant economic impacts, both as additional expenses are incurred by the agency in remediating instances of discrimination or eliminating barriers, and as the resulting nondiscriminatory access to the agency's programs, services and activities results in additional gains for the disabled that have economic value to them.

Regulatory Flexibility Statement

The proposed new rules impose no requirements on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Requirements are imposed on the HMDC, and persons complaining that the HMDC has failed to comply with the ADA must provide certain information in their complaint. A regulatory flexibility analysis is not, therefore, required.

Full text of the proposed new rules follows:

SUBCHAPTER 3. DISABILITY DISCRIMINATION GRIEVANCE PROCEDURE

19:3A-3.1 Definitions

(a) The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"ADA" means the Americans with Disabilities Act, 42 U.S.C.A. §12101 et seq.

"Agency" means the Hackensack Meadowlands Development Commission.

"Designated decision maker" means the Executive Director of the Hackensack Meadowlands Development Commission or his or her designee.

19:3A-3.2 Purpose

(a) These rules are adopted by the agency in satisfaction of the requirements of the ADA and regulations promulgated pursuant thereto, 28 C.F.R. 35.107.

(b) The purpose of these rules is to establish a designated coordinator whose duties shall include assuring that the agency complies with and carries out its responsibilities under the ADA. Those duties shall also include the investigation of any complaint filed with the agency pursuant to N.J.A.C. 19:3A-3.5 through 3.8.

19:3A-3.3 Required ADA Notice

In addition to any other advice, assistance or accommodation provided, a copy of the following notice shall be given to anyone who inquires regarding the agency's compliance with the ADA or the availability of accommodation which would allow a qualified individual with a disability to receive services or participate in a program or activity provided by the agency.

AGENCY NOTICE OF ADA PROCEDURE

The agency has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Justice regulations implementing Title II of the Americans with Disabilities Act. Title II states, in part, that "no otherwise qualified disabled individual shall, solely by reason of such disability, be excluded from participation in, be denied the benefits of or be subjected to discrimination" in programs or activities sponsored by a public entity.

Rules describing ad governing the internal grievance procedure can be found in the New Jersey Administrative Code, N.J.A.C. 19:3A-3.1 et seq. As those rules indicate, complaints should be addressed to the agency's designated ADA Coordinator, who has been designated to coordinate ADA compliance efforts, at the following address.

ADA Coordinator
Hackensack Meadowlands Development Commission
One DeKorte Park Plaza
Lyndhurst, New Jersey 07071

1. A complaint may be filed in writing or orally, but should contain the name and address of the person filing it, and briefly describe the alleged violation. A form for this purpose is available from the designated ADA coordinator. In cases of employment related complaints, the procedures established by the Department of Personnel, N.J.A.C. 4A:7-1.1 et seq. will be followed where applicable.

2. A complaint should be filed promptly within 20 days after the complainant becomes aware of the alleged violation. (Processing of allegations of discrimination which occurred before this grievance procedure was in place will be considered on a case-by-case basis).

3. An investigation, as may be appropriate, will follow the filing of a complaint. The investigation will be conducted by the agency's designated ADA Coordinator. The rules contemplate informal but thorough investigations, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to a complaint.

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4. In most cases a written determination as to the validity of the complaint and a description of the resolution, if any, will be issued by the designated decision maker and a copy forwarded to the complainant no later than 45 days after its filing.

5. The ADA coordinator will maintain the files and records of the agency relating to the complaints filed.

6. The right of a person to a prompt and equitable resolution of the complaint filed hereunder will not be impaired by the person's pursuit of other remedies such as the filing of an ADA complaint with the responsible Federal department or agency or the New Jersey Division on Civil Rights. Use of this grievance procedure is not a prerequisite to the pursuit of other remedies.

7. The rules will be construed to protect the substantive rights of interested persons, to meet appropriate due process standards and to assure that the agency complies with the ADA and implementing Federal rules.

19:3A-3.4 Designated ADA coordinator

(a) The designated coordinator of ADA compliance and complaint investigation for the agency is:

ADA Coordinator
Hackensack Meadowlands Development Commission
One DeKorte Park Plaza
Lyndhurst, New Jersey 07071

(b) All inquiries regarding the agency's compliance with the ADA and the availability of accommodation which would allow a qualified individual with a disability to receive services or participate in a program or activity provided by the agency should be directed to the designated coordinator identified in (a) above.

(c) All complaints alleging that the agency has failed to comply with or has acted in a way that is prohibited by the ADA should be directed to the designated ADA coordinator identified in this section, in accordance with the procedures set forth in N.J.A.C. 19:3A-3.5 through 3.8.

19:3A-3.5 Complaint procedure

A complaint alleging that the agency has failed to comply with the ADA or has acted in a way that is prohibited by the ADA shall be submitted either in writing or orally to the designated ADA coordinator identified in N.J.A.C. 19:3A-3.4. A complaint alleging employment discrimination will be processed pursuant to the rules of the Department of Personnel, N.J.A.C. 4A:7-1.1 through 3.4, if those rules are applicable.

19:3A-3.6 Complaint contents

(a) A complaint submitted pursuant to this subchapter may be submitted in or on the form set forth at N.J.A.C. 19:3A-3.7.

(b) A complaint submitted pursuant to this subchapter shall include the following information:

1. The name of the complainant, and/or any alternate contact person designated by the complainant to receive communication or provide information for the complainant;

2. The address and telephone number of the complainant or alternate contact person; and

3. A description of manner in which the ADA has not been complied with or has been violated, including times and locations of events and names of witnesses if appropriate.

19:3A-3.7 Complaint form

The following form may be utilized for the submission of a complaint pursuant to this subchapter:

Americans with Disabilities Act Grievance Form

Date: _____

Name of grievant: _____

Address of grievant: _____

Telephone number of grievant: _____

Disability of grievant: _____

Name, address and telephone number of alternate contact person:

_____

_____

Agency alleged to have denied access:

Department: _____

Division: _____

Bureau or office: _____

Location: _____

Incident or barrier:

Please describe the particular way in which you believe you have been denied the benefits of any service, program or activity or have otherwise been subject to discrimination. Please specify dates, times and places of incidents, and names and/or positions of agency employees involved, if any, as well as names, addresses and telephone numbers of any witnesses to any such incident. Attach additional pages if necessary.

_____

_____

_____

_____

_____

_____

Proposed access or accommodation:

If you wish, describe the way in which you feel access may be had to the benefits described above, or that accommodation could be provided to allow access.

_____

_____

_____

A copy of the above form may be obtained by contacting the designated ADA coordinator identified at N.J.A.C. 19:3A-3.4.

19:3A-3.8 Investigation

(a) Upon receipt of a complaint submitted pursuant to this subchapter, the designated ADA coordinator will notify the complainant of the receipt of the complaint and the initiation of an investigation into the matter. The designated ADA coordinator will also indicate a date by which it is expected that the investigation will be completed, which date shall not be later than 45 days from the date of receipt of the complaint, unless a later date is agreed to by the complainant.

(b) Upon completion of the investigation, the designated ADA coordinator shall prepare a report for review by the designated decision maker for the agency. The designated decision maker shall render a written decision within 45 days of receipt of the complaint, unless a later date is agreed to by the complainant, which decision shall be transmitted to the complainant and/or the alternate contact person if so designated by the complainant.

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(a)

HACKENSACK MEADOWLANDS DEVELOPMENT COMMISSION

District Zoning Regulations

Proposed Amendments: N.J.A.C. 19:4-2.2, 4.23A, 4.30, 4.39, 4.49, 4.59, 4.69, 4.88, 4.98, 4.107, 4.117, 4.129 and 4.152; 19:4A-3.1, 4.4, 5.3, 5.7 and 6.2

Authorized By: Hackensack Meadowlands Development Commission, Anthony Scardino, Jr., Executive Director.

Authority: N.J.S.A. 13:17 et seq., specifically 13:17-6(i) and 19:4-6.27.

Proposal Number: PRN 1993-483.

A **public hearing** concerning these proposed amendments will be held on Thursday, September 23, 1993 at or after 10:00 A.M. at:

Hackensack Meadowlands Development Commission
One DeKorte Park Plaza
Lyndhurst, New Jersey 07071

Submit written comments by October 7, 1993 to:

Thomas R. Marturano, Acting Chief Engineer
Hackensack Meadowlands Development Commission
One DeKorte Park Plaza
Lyndhurst, NJ 07071

The agency proposal follows:

Summary

The Hackensack Meadowlands Development Commission has recently been accepted in a program called the Community Ratng System, sponsored by the Federal Emergency Management Agency (FEMA). As a condition of the Commission's participation in this program, FEMA reviewed the District's Flood Plain Management regulations. As a result of this review, certain inconsistencies were discovered between the Flood Plain Management and the District Zoning Regulations. The District Zoning Regulations are the regulations used by the Commission on a daily basis to enforce both the zoning and flood plain management requirements. The proposed amendments will not impose any additional requirements to the regulations or change current enforcement procedures. The changes will only result in consistency between these two chapters.

In accordance with the provisions of Executive Order No. 66(1978), the Hackensack Meadowlands Development Commission (HMDC) is required to periodically review its existing regulations to determine their continuing usefulness. Accordingly, the HMDC has undergone a review of its regulations contained in N.J.A.C. 19:4 and N.J.A.C. 19:4A to examine these chapters for congruity and effectiveness with regard to the regulation and enforcement of Flood Plain Management Regulations contained in both chapters.

N.J.A.C. 19:4 contains the District Zoning Regulations. Within this chapter are certan bulk regulations which reflect the design standards enumerated in N.J.A.C. 19:4A. The HMDC proposes substantive amendments within both of these chapters in order to clarify existing regulations governing the construction or substantial improvement of residential and non-residential structures with regard to Flood Plain Management.

N.J.A.C. 19:4-2.2 contains the definitions for the District Zoning Regulations. The proposed amendment would add the definition of "lowest floor" to this section.

N.J.A.C. 19:4-4 represents the zone regulations for the Hackensack Meadowlands District. The bulk regulations listed for each zone currently require that the final finished floor elevation for structures shall be established one foot above the base flood elevation. The proposed amendments to this subchapter would change the wording from "final finished floor" to "lowest floor."

In N.J.A.C. 19:4A-3.1 of the Flood Plain Management Regulations, the definitions of "lowest floor" is proposed to be amended to specifically include areas such as utility rooms, garages, basements and crawl spaces. This change is proposed to satisfy the Federal Emergency Management Agency's requirement for the District's continued participation in the National Flood Insurance Program.

In 19:4A-4.4, the District Zoning regulations currently impose penalties for violations in the Hackensack Meadowlands District. The requirements of the Flood Plain Management regulations are enforced under these zoning regulations. Since the zoning regulations enforce the Flood Plain Management requirements, any violation of these requirements are subject to the penalties outlined in the zoning regulations.

On February 5, 1990 new penalties in the zoning regulations were adopted, however, the penalties in the Flood Plain Management chapter were not revised accordingly. The proposed change would not change the penalties which can be imposed on violations of the Flood Plain Management regulations. The change would only eliminate an inconsistency between the two chapters.

In 19:4A-5.3, the existing text of this section contains a cross-referencing error which will be rectified with the proposed amendment.

In 19:4A-5.7, the Flood Plain Management regulations contain a provision for variance relief. This section states that the procedures which must be followed for a variance for the Flood Plain Management regulations are the same variance procedures outlined in the District Zoning Regulations. The procedures outlined in the zoning regulations limit the amount of time the Commission has to render a variance decision. The amendment is proposed in order to make the two chapters consistent, by providing that the written decision on a variance application shall be rendered within eight weeks of the date of the application's public hearing.

N.J.A.C. 19:4A-6.2 sets the design standards of the Flood Plain Management Regulations. The proposed amendment would require that the "lowest floor" of all new or substantially improved residential and non-residential structures be elevated to a minimum of one foot above the base flood elevation. Currently, this rule requires that the lowest floor be elevated to or above the base flood elevation. The current N.J.A.C. 19:4 regulations already require the higher, more restrictive elevation.

The proposed changes, if adopted in their entirety, will bring clarity and consistency to these two chapters.

Social Impact

The development within the Hackensack Meadowlands District (HMD) is governed in part by N.J.A.C. 19:4 and 19:4A. These chapters include zoning and flood plain management rules. These rules will continue to be applied to the 14 constituent municipalities within the Hackensack Meadowlands District. The proposed amendments to the Flood Plain Management and District Zoning regulations will not impose any new requirements or restrictions, and therefore, no social impact will result from these amendments.

The general provisions of these chapters have had a substantial impact on the development of the 20,000 acres of property located within the District and thus northern New Jersey. Most of these rules have been in effect since 1972. During the period from 1972 to the present, HMDC has reviewed over 12,000 applications seeking approval of zoning certificates, subdivisions, building permits and continued occupancy certificates. These applications have included proposals for industrial, residential and commercial development.

Economic Impact

The impact of these rules on this portion of the State can best be described by indicating that new development in the HMD has generated approximately 6,400 new residences and 90,000 jobs since 1970. In addition, there has been new construction valued at approximately $1.5 billion.

Portions of N.J.A.C. 19:4 and N.J.A.C. 19:4A have been proposed for amendment with the intent of minimizing losses due to flooding. Approximately 75 percent of the HMD lies within the 100 year flood plain. The proposed changes dealing with the lowest floor elevation construction only provide consistency between the District Zoning Regulations and the Flood Plain Management Regulations, and since the enforcement of the lowest floor elevation will not change, then there will be no added cost of construction related to the proposal.

The proposed amendments to the Flood Plain Management Regulations regarding penalties and variances are also currently enforced in the District Zonning Regulations. There will be no economic impact associated with these proposed amendments.

The clarification of these rules should strengthen their impact. The possible economic impact that may result from these changes is the further reduction of flood losses, and the continued reduction in flood insurance premiums for new construction which meets these regulations.

Regulatory Flexibility Statement

The effect of this proposal would be to uniformly regulate development within all areas of the HMD which are located within a 100 year flood plain by clarifying and strengthening existing regulations. These

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amendments will not impose any new restrictions on any development in the District. Small business, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., will not be affected; therefore, no regulatory flexibility analysis is required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:4-2.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Lowest floor" means the lowest floor of the lowest enclosed area, including basement, cellar, crawl space, garage, and utility room. An unfinished or flood resistant enclosure, usable solely for the parking of vehicles, building access or storage in an area other than a basement, is not considered a building's lowest floor provided that such enclosure is not built so as to render the structure in violation of other applicable non-elevation design requirements.

. . .

19:4-4.23A Planned park zone 1; bulk regulations

(a) The bulk regulations for the planned park zone are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.30 Low density residential zone; bulk regulations

(a) Bulk regulations in the low density residential zone [include] **are**:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.39 Waterfront recreation zone; bulk regulations

(a) The bulk regulations in the waterfront recreation zone are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

6. (No change.)

19:4-4.49 Highway commercial zone; bulk and density regulations

(a) The bulk and density regulations in the highway commercial zone are:

1.-6. (No change.)

7. Minimum [final finished] **lowest** floor elevations for structures within designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.59 Service-highway commercial zone; bulk requirements

(a) The bulk requirements [for] **in** the service-highway commercial zone are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within the designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.69 Research park zone; bulk regulations

(a) The bulk regulations in the research park zone are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within the designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.88 Light industrial zone A; bulk regulations

(a) The bulk regulations in **the** light industrial zone A are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.98 Light industrial zone B; bulk regulations

(a) The bulk regulations in **the** light industrial zone B are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within the designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.107 Heavy industrial zone; bulk regulations

(a) The bulk regulations in the heavy industrial zone are:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within the designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.117 Airport facilities zone; bulk regulations

(a) The bulk regulations in the airport facilities zone [include] **are**:

1.-3. (No change.)

4. Minimum [final finished] **lowest** floor elevations for structures within the designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.129 Public utilities zone; bulk regulations

(a) The bulk regulations in the public utilities zone are:

1.-3. (No change.)

4. Minimum [final finished] **lowest** floor elevations for structures within the designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

19:4-4.152 Commercial Park Zone: Bulk regulations

(a) The [following are] bulk regulations in the Commercial Park Zone **are**:

1.-4. (No change.)

5. Minimum [final finished] **lowest** floor elevations for structures within designated 100 year flood zones shall be established one foot above the applicable 100 year base **flood** elevations determined by the Federal Emergency Management Agency's (FEMA) Flood Insurance Rate Maps (FIRM).

6. (No change.)

19:4A-3.1 Words and phrases defined

Unless specifically defined below, words or phrases used in this chapter shall be interpreted so as to give them the meaning they have in common usage and to give this chapter its most reasonable application.

. . .

"Lowest floor" means the lowest floor of the lowest enclosed area, including basement, **cellar, crawl space, garage, and utility room**. An unfinished or flood resistant enclosure, usable solely for the parking of vehicles, building access or storage in an area other than

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a basement is not considered a building's lowest floor provided that such enclosure is not built so as to render the structure in violation of other applicable non-elevation design requirements.

. . .

19:4A-4.4 Penalties and enforcement

(a) No structure or land shall hereafter be constructed, located, extended, converted or altered without full compliance with the terms of this chapter and other applicable regulations. Any person who violates the provisions of this chapter or fails to comply with any of its requirements shall be subject to a [fine not to exceed $200.00 or to imprisonment for not more than 30 days] **civil penalty of not less tha $200.00 or more than $5,000**. Each day such violation or failure to comply is permitted to exist after notification thereof shall constitute a separate offense. In addition to the foregoing, the Commission may, in the case of any such violation or threat of such violation, institute civil action.

1.-6. (No change.)

19:4A-5.3 Duties and responsibilities of the Office of the Chief Engineer

(a) The Office of the Chief Engineer shall administer the provisions of this chapter in the manner set forth herein and in furtherance of such authority, shall, but not limited to:

1.-5. (No change.)

6. When base flood elevation data has not been provided in accordance with N.J.A.C. 19:4A-4.2, Basis for establishing the areas of special flood hazard, the Office of the Chief Engineer shall obtain, review, and reasonably utilize any base flood data available from a Federal, State, or other source, in order to administer N.J.A.C. [19:4] **19:4A**.

7. (No change.)

19:4A-5.7 Written decision and records

A written decision on an application for a variance shall be rendered within [10] **eight** weeks of the date of the [application] **public hearing**. The Office of the Chief Engineer shall maintain complete records of all actions with respect to applications for variances, including technical information, and shall report any variances to the Federal Emergency Management Agency upon request.

19:4A-6.2 Buildings

(a) Residential construction: New construction and substantial improvement of any residential structure shall have the lowest floor[, including basement,] elevated to [or] **a minimum of one foot** above **the** base flood elevation.

(b) Non-Residential [Construction] **construction**: New construction and substantial improvement of any commercial, industrial or other non-residential structure shall either have the lowest floor[, including basement,] elevated [or] **a minimum of one foot** above **the** base flood elevation, or together with utilities shall:

1. Be floodproof, so that below the [flood level] **elevation equal to one foot above the base flood elevation,** the structure is water tight with walls impermeable to the passage of water;

2.-3. (No change.)

(c) (No change.)

(d) All manufactured homes to be placed or substantially improved within an area of special flood hazard shall be elevated on a permanent foundation such that the top of the lowest floor is [at or] **elevated to a minimum of one foot** above the base [floor] **flood** elevation.

(a)

CASINO CONTROL COMMISSION

Applications
Vendor Registration Form
Junket Enterprise Registration Form

Proposed New Rules: N.J.A.C. 19:41-5.11 and 5.12
Proposed Amendment: N.J.A.C. 19:41-5.1

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63c, 69a, 70a, 102 and 104b.

Proposal Number: PRN 1993-463.

Submit written comments by October 7, 1993 to:
Mary S. LaMantia, Counsel
Casino Control Commission
Tennessee and Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

In accordance with subsection 92c of the Casino Control Act ("the Act"), N.J.S.A. 5:12-1 et seq., Casino Control Commission ("Commission") regulations provide that any enterprise which enters into an agreement to provide goods and services "regarding the realty, construction, maintenance or business" of a casino hotel or related facility, or which transacts business with a casino licensee or hub facility with respect to casino simulcasting, must have a Vendor Registration Form ("VRF") filed on its behalf with the Casino Control Commission ("Commission"). N.J.A.C. 19:41-11.1(c); N.J.A.C. 19:55-6.4. Likewise, an enterprise or individual that conducts junket business with a casino licensee or applicant must have a Junket Enterprise Registration Form ("JERF") filed on its behalf. N.J.A.C. 19:41-11.1(d). Licensure pursuant to subsection 92c of the Act is required when these enterprises conduct such business on a "regular and continuing basis." N.J.A.C. 19:51-1.2(c) and (d).

Upon filing of the registration form, the enterprise is added to the Commission's Master Vendors List, which is periodically updated and distributed to casino hotels.

Proposed new rules N.J.A.C. 19:41-5.11 and 5.12 describe the information requested in the VRF and the JERF. These forms were recently reviewed and revised by the Commission in cooperation with the Division of Gaming Enforcement. The proposed amendment to N.J.A.C. 19:41-5.1 simply references the definition of "hub facility." New rules at N.J.A.C. 19:41-5 are adopted elsewhere in this issue of the New Jersey Register.

Social Impact

The proposed new rules outline the content of the registration forms required to be filed with the Commission by casino licensees and applicants on behalf of the nongaming-related enterprises and junket enterprises with which they do business. The rules should prove useful to such enterprises, and to those who are considering entering into such agreements, by providing a readily available, comprehensive listing of the requisite data which must be disclosed to the Commission in order to do business with the Atlantic City Casino Industry.

Economic Impact

The rules are not anticipated to have any significant economic impact. Those casino licensees and applicants who file the forms described in the rules, and those enterprises involved, incur some time and expense in compiling the requisite information and in completing and filing the forms. The regulatory agencies likewise incur costs in reviewing and processing these disclosure forms. However, the Commission has always required this type of disclosure as part of the registration process. The rules herein simply codify Commission forms, which in itself should not result in any incremental economic impact.

Regulatory Flexibility Statement

The proposed new rules affect certain junket enterprises and nongaming-related enterprises doing business with casino licensees or applicants, some of which may qualify as a small business under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The new rules outline the information and data which such businesses must provide to the Commission through completion of the VRF and JERF. The businesses will expend some administrative time and expense

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in compiling the requisite information, and in completing and filing the forms, but such costs should not be unduly burdensome in view of the types of information requested.

It would not be feasible to exempt small businesses from these rules, or to allow a different standard of compliance. Adequate disclosure must be required of all such enterprises, without regard to size, consistent with the mandate of the Casino Control Act to extend strict regulation to not only casino operations but also to the ancillary industries. N.J.S.A. 5:12-1b(6), 1b(9).

Full text of the proposal follows (additions indicated in boldface **thus**:

19:41-5.1 Definitions

The following words and terms shall have the following meanings when used in this subchapter, unless the context clearly indicates otherwise.

. . .

"Hub facility" is defined at N.J.A.C. 19:55-1.1.

. . .

19:41-5.11 Vendor Registration Form

(a) A Vendor Registration Form (VRF) shall be in a format prescribed by the Commission and may require the following information regarding the enterprise:

1. Any official or trade name used;

2. Business address;

3. Telephone number;

4. The nature of the business and the type of goods or services being provided to the casino industry or hub facility;

5. Federal Employer Identification Number;

6. State and date of incorporation;

7. Whether the enterprise is minority- or women-owned and controlled and the enterprise certification number, if any, which information is voluntarily provided;

8. Form of business;

9. The date on which a formal offer and acceptance of the agreement to conduct business with a casino licensee or applicant or hub facility occurred;

10. Names and addresses of all subsidiaries;

11. The name, address and percentage of ownership of each entity directly owning more than five percent of the enterprise;

12. The names of each of the following:

i. Any individual who entered into the agreement with or will deal directly with the casino licensee or applicant or hub facility, including sales representatives; the immediate supervisors of such persons; and all persons responsible for the office out of which such supervisors work;

ii. Any officer, partner, or director who will be significantly involved in the conduct of the enterprise's business with the casino licensee or applicant or hub facility;

iii. If the enterprise is a sole proprietorship, the name of the sole proprietor; and

iv. Each beneficial owner of more than five percent of the outstanding voting securities of the enterprise, and the percentage of ownership; and

13. The name and position or title of the individual who supplied the information in the VRF.

(b) In addition to the information in (a) above, a completed VRF may include the following:

1. A certification of truth, which shall be dated and signed by an authorized agent of the casino licensee or applicant or hub facility, and which shall indicate such person's position or title and the casino licensee or applicant or hub facility submitting the form; and

2. A Principal Employee Data Summary Form for each individual in (a)12i through iv above, which may include the following information:

i. Name;

ii. Residence;

iii. Date of birth;

iv. Sex and race, which information is voluntarily provided;

v. Position with the enterprise; and

vi. Any gaming licenses or registrations currently held or pending in the State.

19:41-5.12 Junket Enterprise Registration Form

(a) A Junket Enterprise Registration Form (JERF) shall be in a format prescribed by the Commission and may require the junket enterprise to provide the following information:

1. Any official or trade name used;

2. Business address;

3. Telephone number;

4. Federal Employer Identification Number;

5. State and date of incorporation;

6. Whether the enterprise is minority- or women-owned and controlled and the enterprise certification number, if any, which information is voluntarily provided;

7. Form of business;

8. Names and addresses of all subsidiaries;

9. The name, address and percentage of ownership of each entity directly owning more than five percent of the enterprise;

10. The names of each of the following:

i. Any individual who entered into the agreement with the casino licensee or applicant and any individual who will deal directly with the casino licensee or applicant, including junket representatives; the immediate supervisors of such persons; and all persons responsible for the office out of which such supervisors work;

ii. Any officer, partner, or director who will be significantly involved in the conduct of the enterprise's business with the casino licensee or applicant;

iii. If the enterprise is a sole proprietorship, the name of the sole proprietor; and

iv. Each beneficial owner of more than five percent of the outstanding voting securities of the enterprise, and the percentage of ownership;

11. The name, date of birth, address and telephone number of any junket representative employed by the enterprise who is utilized in the conduct of junket activity but who is not listed in (a)10i above.

(b) In addition to the information in (a) above, a completed JERF may include the following:

1. A certification of truth, which shall be dated and signed by an officer or owner of the junket enterprise and shall indicate such person's position or title;

2. A Principal Employee Data Summary Form for each individual in (a)10i through iv above, which may include the following information:

i. Name;

ii. Residence;

iii. Date of birth;

iv. Sex and race, which information is voluntarily provided;

v. Position with the enterprise; and

vi. Any gaming licenses or registrations currently held or pending in the State; and

3. A Junket Enterprise Transmittal Form, which may include the following:

i. The anticipated date of arrival for the first junket involving the junket enterprise; and

ii. A certification of truth, which shall be dated and signed by an authorized agent of the casino licensee or applicant, and shall indicate such person's position or title.

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(a)

CASINO CONTROL COMMISSION

Rules of the Games
Minimum and Maximum Wagers
Reproposed Amendments: N.J.A.C. 19:45-1.12A; 19:47-1.3, 2.3, 2.6, 3.2, 5.1, 5.6, 7.2 and 9.3
Reproposed Repeals: N.J.A.C. 19:47-4.2, 6.6, 10.10, 11.12 and 12.10
Reproposed Repeal and New Rule: N.J.A.C. 19:47-8.2

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.
Authority: N.J.S.A. 5:12-63(c), 69(a), 70(f), 99(a)16 and 100(e).
Proposal Number: PRN 1993-484.

Submit written comments by October 7, 1993 to:
Seth H. Briliant, Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, N.J. 08401

The agency proposal follows:

Summary

On May 17, 1993, a proposal was published in the New Jersey Register at 25 N.J.R. 1958(a) which would change the manner in which the Commission regulates minimum and maximum wagers, as well as the "spread" between those wagers. In addition to eliminating minimum wagers, the proposal would have permitted casino licensees to set their own maximum wager limits, subject only to the general requirement that for all minimum wagers of $100.00 or less, where the odds are 10 to one or less, the corresponding maximum wager must be at least 10 times the minimum wager.

Three comments were received. Greate Bay Hotel & Casino Inc. (Sands Hotel & Casino) supported the proposal, and the Division of Gaming Enforcement did not object to it. Boardwalk Regency Corporation (Caesars Atlantic City) generally supported the proposal, but objected to certain provisions of proposed N.J.A.C. 19:47-8.2(a), which would require a casino licensee to offer what it considers to be an unreasonably high maximum bet for "inside wagers" at roulette (corner and line bets), and creating an unacceptable risk. Caesars suggested that the phrase "wager of $100.00 or less" be changed to "wager of less than $100.00."

After reviewing the comments, the Commission has decided to modify the proposal to address this concern. Although the "$100.00 or less wager" requirement has not been changed, the "10 to one or less" odds requirement has been reduced to "five to one or less" odds. This would exclude from the minimum required spreads the roulette bets which Caesars believes pose an unacceptable risk. However, the reproposal would still address the basic issue of a minimum required spread, and would preserve that requirement for lower-odds wagers of $100.00 or less.

The remainder of the original proposal remains unchanged and is being reproposed at this time. Different maximum wagers could be offered at one gaming table for each permissible wager in an authorized game, and different maximums could be offered at different gaming tables for the same wager in an authorized game. See N.J.A.C. 19:47-8.2(b). To comply with recent legislative amendments deleting the reference to minimum wagers in section 100(e) of the Casino Control Act, see N.J.S.A. 5:12-100(e), this proposal would delete existing N.J.A.C. 19:47-8.2(a), which requires a casino licensee to obtain Commission approval of its minimum wagers.

The amendments would also delete the cross-references to N.J.A.C. 19:47-8.3 now found in N.J.A.C. 19:47-1.3, 2.3, 3.2, 4.2, 5.1, 5.6, 6.6, 7.2, 8.2, 9.3, 10.10, 11.12, and 12.10. Instead, N.J.A.C. 19:47-8.2(c) would provide, as a general rule, that a casino licensee must provide notice of its minimum and maximum wagers, and any changes thereto, at each gaming table, in the manner specified in N.J.A.C. 19:47-8.3. However, no notice to the Commission would be required for any increase or decrease in the minimum wager, see N.J.A.C. 19:47-8.3(b) and (c), or any change in the maximum wager, see N.J.A.C. 19:47-8.3(c).

A new subsection, N.J.A.C. 19:47-8.2(d), would provide, in accordance with section 100(g) of the Act, that a wager which exceeds the maximum limit when placed, but is accepted by the dealer, would be paid or lost in its entirety, as the case may be, despite the fact that it exceeded the table limit. This would codify the existing practice of permitting casino licensees to "waive" the maximum wager limit for one or more patrons at a table; it would also apply to the mistaken or inadvertent acceptance of a wager in excess of the table limit.

The Commission welcomes comments on this reproposal from the original respondents or from other interested parties. Please note that the reproposal supersedes the previous proposal, and that any comments submitted in response to the earlier proposal, having already been considered, will not be considered in connection with this proposal.

Social Impact

These proposed amendments, repeals and new rule would simplify and streamline the way casino licensees may set their minimum and maximum wagers, while striking what the Commission considers to be an appropriate balance between the goals of casino vitality and maximum player participation. These amendments, repeals and new rules would ensure that casino patrons will have sufficient flexibility to increase their wagers in meaningful amounts on routine and lower-odds wagers when they believe it is prudent to do so, thus affording them the maximum participation mandated by section 100(e) of the Act. However, casino licensees would still be free to impose whatever maximum bet requirements they believe are necessary on larger and higher-odds wagers, in order to limit their risk and to protect the vitality of their casino operations.

Economic Impact

Because of the complex interaction between wager limits and other factors involving a patron's casino play or a casino licensee's operation, the economic impact of the proposed amendments, repeal and new rule is unknown. However, because of the considerable flexibility which casino licensees already enjoy with regard to setting minimum and maximum wagers, no major economic impact to the public or casino licensees is anticipated.

Regulatory Flexibility Statement

The proposed amendments, repeals and new rule would affect casino licensees and their patrons, none of which is a "small business" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Accordingly, no regulatory flexibility analysis is required.

Full text of the reproposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:45-1.12A Personnel assigned to the operation and conduct of low limit table games

(a) Notwithstanding the provisions of N.J.A.C. 19:45-1.12 or any other Commission rule to the contrary, a casino licensee may offer table games which do not meet the minimum staffing requirements of N.J.A.C. 19:45-1.12 provided that:

1. The maximum wager [permitted] on such table games shall be $25.00;

2. [Any] **The** minimum wager [required] on such table games shall be no higher than $5.00; and

3. (No change.)

(b)-(c) (No change.)

19:47-1.3 Making and removal of wagers[; approval of minimum wagers]

(a)-(e) (No change.)

[(f) Each casino licensee shall submit to the Commission for its review and approval in accordance with N.J.A.C. 19:47-8.2 the proposed minimum wagers to be permitted at each craps table in the casino and the casino simulcasting facility. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each craps table.]

19:47-2.3 Wagers

(a)-(d) (No change.)

[(e) Each casino licensee shall submit to the Commission for review and approval in accordance with N.J.A.C. 19:47-8.2 the minimum wagers permitted at each blackjack table in the casino and

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the casino simulcasting facility. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each blackjack table.]

Recodify existing (f)-(h) as **(e)-(g)** (No change in text.)

[(i)]**(h)** No dealer or other casino employee or casino key employee shall permit any player to engage in conduct violative of [subsections (g) or (h)] **(f) or (g) above** [of this section].

Recodify existing (j)-(k) as **(i)-(j)** (No change in text.)

[l] **(k)** If a double shoe is utilized, the term "first card" as used in (a), (c) and [(g)] **(f)** above shall mean "determinant card."[.]

19:47-2.6 Procedure for dealing of cards

(a)-(j) (No change.)

(k) In lieu of the procedure set forth in (h) above, a casino licensee may permit a blackjack dealer to deal his or her hole card face upward after a second card and before additional cards are dealt to the players, provided that the casino licensee complies with the notice requirements set forth in N.J.A.C. 19:47-8.3. Notwithstanding any other provision of this subchapter, the following rules shall apply whenever cards used to game at blackjack are dealt in accordance with this subsection:

1. (No change.)

2. Winning wagers shall be paid in accordance with N.J.A.C. 19:47-2.3[(f)]**(e)**, except that standard blackjack shall be paid at odds of 1 to 1;

3.-5. (No change.)

(l)-(o) (No change.)

19:47-3.2 Wagers

(a)-(d) (No change.)

[(e) Each casino licensee shall submit to the Commission for review and approval in accordance with N.J.A.C. 19:47-8.2 the minimum wagers permitted at each Baccarat-Punto Banco table. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each Baccarat-Punto Banco table.]

19:47-4.2 [Minimum and maximum wagers] **(Reserved)**

[Each casino licensee shall submit to the Commission for review and approval in accordance with N.J.A.C. 19:47-8.2 the minimum wagers permitted at each Baccarat-Chemin de Fer table. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers at each Baccarat-Chemin de Fer table.]

19:47-5.1 Wagers

(a)-(d) (No change.)

[(e) Each casino licensee shall submit to the Commission for review and approval in accordance with N.J.A.C. 19:47-8.2 the minimum wagers permitted at each roulette table in the casino and the casino simulcasting facility. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each roulette table.]

19:47-5.6 Big Six Wheel; wagers and rotation of the wheel

[(a) Each casino licensee shall submit to the Commission for review and approval in accordance with N.J.A.C. 19:47-8.2 the minimum wagers permitted at each Big Six Wheel in the casino and the casino simulcasting facility. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each Big Six table.]

Recodify existing (b)-(f) as **(a)-(e)** (No change in text.)

19:47-6.6 [Minimum wagers] **(Reserved)**

[(a) Each casino licensee shall submit to the Commission for review and approval, in accordance with N.J.A.C. 19:47-8.2, the minimum wagers permitted at each red dog table.

(b) Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each red dog table.]

19:47-7.2 Wagers

(a)-(d) (No change.)

[(e) Each casino licensee shall submit to the Commission for review and approval in accordance with N.J.A.C. 19:47-8.2 the minimum wagers permitted at each minibaccarat table. Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each minibaccarat table.]

Recodify existing (f) as **(e)** (No change in text.)

19:47-8.2 Minimum and maximum wagers

[(a) Each casino licensee or applicant shall submit to the Commission a proposal specifying the minimum wagers and any other limitations at all authorized table games in its casino or casino simulcasting facility. Such submission shall be made at least 30 days before gaming operations are to commence or before changes in a previously submitted proposal are to become effective, unless otherwise permitted by the Commission. Each such submission shall contain, but not be limited to the following information:

1. A floor plan of the casino and the casino simulcasting facility showing the location and configuration of all table games authorized by the Commission or proposed by the licensee or applicant for authorization;

2. The number of such table games, by game, authorized by the Commission or proposed by the licensee or applicant for such authorization in the licensee's or applicant's casino or casino simulcasting facility;

3. The minimum and maximum amount that the applicant or licensee will permit patrons to place on the possible wagers at each gaming table (forms will be provided by the Commission).

4. For the purposes of this regulation:

i. "Table games authorized by the Commission" means the total number of table games which the casino licensee is permitted to operate under the terms of its operation certificate;

ii. "Table games proposed by the licensee or applicant for authorization" means the total number of table games which the casino licensee or casino license applicant requests permission to operate under the terms of an operating certificate;

iii. "Table game open for play" means a table game staffed by the required number of dealers and supervisory personnel and in all respects available for gaming.

(b) The spread between the minimum wager and the maximum wager at table games shall be as follows:

1. Blackjack: If the minimum wager at a table is $5.00 or less, the maximum wager shall be at least $100.00;

2. Craps: If the minimum wager at a table is $5.00 or less, the maximum wager shall be at least $500.00; provided, however, that the maximum wager on the pass, don't pass, come, or don't come shall not preclude a casino patron from taking the odds or laying the odds in accordance with the regulations of the Commission relating to craps;

3. Roulette: If the minimum wager at a table is:

i. Less than $5.00, the maximum wager shall be at least:

(1) $1,000 on an even-money wager;

(2) $500.00 on wager where the odds are two to one;

(3) $50.00 on an inside wager, any way the patron can get to the number;

ii. $5.00, the maximum wager shall be at least:

(1) $2,000 on an even-money wager;

(2) $1,000 on a wager where the odds are two to one;

(3) $100.00 on an inside wager, any way the patron can get to the number;

4. Big Six Wheel: The minimum wager shall be $5.00 or less and the maximum wagers shall be at least:

i. $400.00 on a wager where the odds are even money;

ii. $200.00 where the odds are two to one;

iii. $80.00 where the odds are five to one;

iv. $50.00 where the odds are ten to one;

v. $50.00 where the odds are twenty to one;

vi. $50.00 where the oods are forty-five to one.

5. Baccarat:

i. If the minimum wager at a table is $50.00 or less the maximum wager shall be at least $2,000.

6. Minibaccarat:

i. If the minimum wager at the table is $5.00 or less, the maximum wager shall be at least $100.00.

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7. Red Dog:

i. If the minimum wager at a table is $5.00 or less, the maximum wager shall be at least $100.00.

8. Sic bo:

i. If the minimum wager at the table is $5.00 or less, the maximum wager shall be at least $100.00. Nothing in this chapter shall preclude a casino licensee from establishing different maximum wagers for each wager at the game of sic bo, provided, however, that such limitations are posted at the table.

9. Pai gow:

i. If the minimum wager at the table is $5.00 or less, the maximum wager shall be at least $100.00.

10. Pai gow poker:

i. If the minimum wager at the table is $5.00 or less, the maximum wager shall be at least $100.00.

11. Pokette:

i. If the minimum wager at a table is $5.00 or less, the maximum wager shall be at least $40.00. Nothing in this chapter shall preclude a casino licensee from establishing different maximum wagers for each permissible wager at the game of pokette; provided, however, that such limitations are posted at the table.

(c) A casino licensee shall provide notice of changes in the permissible minimum and maximum wagers at table games in accordance with N.J.A.C. 19:47-8.3.]

(a) Except as otherwise specifically provided in this chapter, the minimum and maximum wagers permitted at any authorized table game in a casino or casino simulcasting facility shall be established by the casino licensee; provided however, that any required minimum wager of $100.00 or less which has corresponding payout odds of five to one or less shall be required to have a maximum wager which is at least 10 times the amount of the minimum wager.

(b) A casino licensee may offer:

1. Different maximum wagers at one gaming table for each permissible wager in an authorized game; and

2. Different maximum wagers at different gaming tables for each permissible wager in an authorized game.

(c) A casino licensee shall provide notice of the minimum and maximum wagers in effect at each gaming table, and any changes thereto, in accordance with N.J.A.C. 19:47-8.3.

(d) Any wager accepted by a dealer which is in excess of the established maximum permitted wager at that gaming table shall be paid or lost in its entirety in accordance with the rules of the game, notwithstanding that the wager exceeded the current table maximum.

19:47-8.3 Rules of the games; notice

(a) (No change.)

(b) Except as provided in (c) below, no casino licensee shall change the rules pursuant to which a particular table game is being operated unless, at least one-half hour in advance of such change, the casino licensee:

1.-2. (No change.)

3. Notifies the Commission of the rule change, the gaming table where it will be implemented and the time that it will become effective, **provided however, that the Commission need not be notified of increases in minimum wagers.**

(c)-(d) (No change.)

19:47-9.3 Wagers

(a)-(c) (No change.)

[(d) Each casino licensee shall submit to the Commission for review and approval, in accordance with N.J.A.C. 19:47-8.2, the minimum wagers permitted at each sic bo table.

(e) Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each sic bo table.]

[19:47-10.10 Minimum and maximum wagers

(a) Each casino licensee shall submit to the Commission for review and approval, in accordance with N.J.A.C. 19:47-8.2, the minimum wagers permitted at each pai gow table.

(b) Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each pai gow table.]

Recodify existing N.J.A.C. 19:47-10.11 as **10.10** (No change in text.)

[19:47-11.12 Minimum and maximum wagers

(a) Each casino licensee shall submit to the Commission for review and approval, in accordance with N.J.A.C. 19:47-8.2, the minimum wagers permitted at each pai gow poker table.

(b) Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each pai gow poker table.]

Recodify existing N.J.A.C. 19:47-11.13 as **11.12** (No change in text.)

[19:47-12.10 Minimum and maximum wagers

(a) Each casino licensee shall submit to the Commission for review and approval, in accordance with N.J.A.C. 19:47-8.2, the minimum wagers permitted at each pokette table.

(b) Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each pokette table.]

(a)

CASINO CONTROL COMMISSION

Equal Employment and Business Opportunity Provisional Certification of Women and Minority Businesses; Ineligibility of Successor Businesses

Proposed Amendments: N.J.A.C. 19:53-1.2 and 5.4

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63, 69, 75, 134 and 135.

Proposal Number: PRN 1993-485.

Submit written comments by October 7, 1993 to:

David C. Missimer, Assistant General Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

On July 21, 1993, the Commission adopted a new chapter of rules concerning the equal opportunity and affirmative action obligations which are imposed on persons regulated by the provisions of the Casino Control Act, N.J.S.A. 5:12-1 et seq. (25 N.J.R. 3843(b)). Included in these new rules are various provisions regulating the relationship of casino licensees with women business enterprises (WBEs) and minority business enterprises (MBEs).

One of the more common concerns expressed to the Commission during the development and adoption of these rules was that the benefits anticipated to accrue to WBEs and MBEs as a result of the adoption of the new rules could be significantly diminished if the Commission did not take strong measures to prevent or sanction the provisional certification of enterprises which fraudulently represent their WBE or MBE status. Of particular concern were "front companies," enterprises which are formed by non-certifiable business owners transferring assets or complete businesses to "new" women or minority owners who are in reality family members or associates of the previous owners and who obtain "ownership" for the sole purpose of enabling the enterprise to qualify for WBE or MBE certification.

In order to address the problem of front companies in a comprehensive manner, the Commission has determined to propose additional amendments to N.J.A.C. 19:53 concerning "successor businesses." The proposed amendment to N.J.A.C. 19:53-1.2 defines a "successor business" as an enterprise which satisfies the definition of an MBE or WBE but was acquired within the past two years, as a ongoing business or through a purchase of assets, from a person or persons in whose ownership or control the enterprise would not qualify as an MBE or WBE.

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The amendment to N.J.A.C. 19:53-5.4 being proposed by the Commission would make all successor businesses ineligible for provisional certification as an MBE or WBE. Successor businesses would be permitted, however, to apply for certification as an MBE or WBE by the Department of Commerce and Economic Development (DCED). It is anticipated that DCED would also propose additional amendments to its uniform certification rules, N.J.A.C. 12A:11-1, which would require successor businesses to establish certain facts and overcome certain presumptions related to the establishment and management of a successor business in order to obtain MBE or WBE certification.

Social Impact

The proposed amendments to N.J.A.C. 19:53-1.2 and 5.4 should help to assure that the minority and women business enterprises which were intended to benefit from the affirmative requirements imposed on casino licensees by the Commission's equal employment and business opportunity rules actually do so. Conversely, the amendments will, by their terms, preclude all successor businesses from obtaining provisional certification. Thus, the decision whether to adopt the proposed amendments will depend in large part on a balancing of the interests of all WBEs and MBEs in preventing the provisional certification of front companies against the interests of those WBEs and MBEs which are successor businesses acquired in legitimate arm's length transactions.

Economic Impact

The most significant potential economic impact of the rules would be on successor businesses since these businesses would no longer be eligible for provisional certification as an MBE or WBE. Assuming that the status of an enterprise as a provisionally certified MBE or WBE is an important factor to a casino licensee when it decides to do business with a particular enterprise, the inability of a successor business to obtain provisional certification could have some negative economic impact on such businesses. This potential impact on a successor business could be minimized, however, by the prompt filing by the successor business of an application for DCED certification. The proposed amendments are not anticipated to have any significant economic impact on the general public, the regulatory agencies or casino licensees.

Regulatory Flexibility Analysis

The proposed amendments may affect various enterprises which would qualify as a small business under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments do not, however, impose any reporting or recordkeeping requirements on such enterprises. At most, such enterprises may be required to certify to the Commission at the time they seek provisional certification that they are not in fact a successor business. Although it is possible that some less sophisticated small businesses may require some professional assistance in determining whether they meet the definition of "successor business," it is anticipated that the vast majority of business enterprises will be able to answer this question without any assistance whatsoever. Therefore, no differing standards based on business size are offered.

Full text of the proposal follows (additions indicated in boldface **thus**):

19:53-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Successor business" means a business enterprise which satisfies the definition of MBE or WBE set forth in N.J.A.C. 19:53-5.4 but, within the past two years, either was acquired as an ongoing business or more than 50 percent of the assets of the business, as valued in accordance with generally accepted accounting principles, were acquired, other than by inheritance, from a person or persons in whose ownership or control the business enterprise would not qualify as an MBE or WBE.

. . .

19:53-5.4 Provisional certification of minority and women businesses

(a) An enterprise may qualify for provisional certification as an MBE, a WBE, or both. **A successor business is not eligible for provisional certification as an MBE or WBE pursuant to this section but may apply for DCED certification as an MBE or WBE by complying with the requirements of N.J.A.C. 12A:11.**

(b)-(j) (No change.)

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

WATER SUPPLY ELEMENT

Standards and Procedures for Establishing Privileges to Divert Water and for Obtaining Water Usage Certifications for Agricultural or Horticultural Purposes

Proposed Readoption with Amendments: N.J.A.C. 7:20A

Authorized By: Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection & Energy.

Authority: N.J.S.A. 13:1B-3, 13:1D-9 and 58:1A-1 et seq.

DEPE Docket Number: 45-93-08/39.

Proposal Number: PRN 1993-494.

Submit written comments, identified by the Docket Number given above, by October 7, 1993, to:

Janis E. Hoagland, Esq.
Office of Legal Affairs
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

The agency proposal follows:

Summary

Pursuant to the requirements and criteria of Executive Order No. 66(1978), N.J.A.C. 7:20A expires on December 16, 1993. The Department of Environmental Protection and Energy (Department) has reviewed the rules and determined that the requirements set forth therein are necessary, reasonable, and proper for the purpose for which they were originally promulgated. The Department proposes to readopt the chapter with minor modifications.

A new subchapter, N.J.A.C. 7:20A-3, is being proposed which will require those persons who have the capability to divert 100,000 or more gallons of water per day, but who divert less than that quantity for agricultural or horticultural purposes, to register the diversion with the county agricultural agent. The Department is also proposing amendments which provide the procedures for the installation of replacement wells and for handling complaints of interference.

The Department is also proposing that applications for certifications for diversions in the Pinelands or for diversions in excess of 500,000 gallons of water per day located outside of the Pinelands be reviewed by the county agricultural agent instead of being referred to the Department. These changes have been developed with the county agricultural agents and the Pinelands Commission for ease of administration of the program.

The Department is proposing a one-time, two-year extension for certifications, with approved diversions of less than 500,000 gallons per day, which will expire in 1994 and 1995. This extension will even out the number of certifications expiring each year which will allow the county agents and the Department to more efficiently process the renewal of certifications.

Since the Division of Water Resources no longer exists within the Department, all references to the former Division have been deleted. The Department of Environmental Protection has been renamed the Department of Environmental Protection and Energy; accordingly, this change has been made throughout the chapter.

The readoption of these rules will continue to provide the mechanism whereby the State serves as the consultant to the appropriate county agricultural agent to provide recommendations concerning the approval or disapproval of applications for water usage certification.

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The rules have enabled the State to obtain valuable information about water use and sources of supply for agricultural purposes. This information is an essential component of the Statewide water resource management strategy.

Following is a summary of the provisions of each section of the chapter proposed for readoption and/or amendment:

N.J.A.C. 7:20A-1.1, Scope and authority, has been amended to cover agricultural and horticultural users who have the ability to divert 100,000 or more gallons of water per day.

N.J.A.C. 7:20A-1.2, Construction, provides that the chapter is to be liberally construed in order to implement the purposes of the Water Supply Management Act.

N.J.A.C. 7:20A-1.3, Definitions, defines the words and terms which are used in the chapter. The terms "Division" and "Pinelands area" have been deleted because they are not used in the language of the chapter as proposed for readoption. The term "appropriate county agricultural agent" has been incorporated into the definition of "county agricultural agent." The term "agricultural water use registration" has been added to define the process by which persons who have the capability to divert 100,000 or more gallons of water per day but who divert less than that quantity for agricultural or horticultural purposes must register the diversion with the county agricultural agent. The term "replacement well" has been added to define what kind of new well will be considered a replacement well. The term "water supply allocation permit" has been added to describe the permit that is required for users of 100,000 or more gallons of water per day for non-agricultural and non-horticultural uses.

The definition of "agricultural or horticultural purposes" has been amended to include all crop types. The definition of "applicant" has been amended to include persons applying for water use registrations. The definitions of "Commissioner" and "Department" have been amended to reflect the Department's revised name. The terms "critical aquifer" and "critical water supply area" have been redefined as "water supply critical aquifer" and "water supply critical area" to be consistent with the definitons in N.J.A.C. 7:19-1.3. The definition of "modification" has been revised to exclude a change in agricultural or horticultural activity and to include an increase in pump capacity of an existing source as a basis for requesting a change to a certification.

N.J.A.C. 7:20A-1.4, Applicability, has been amended to include persons having the capability to divert 100,000 or more gallons of water per day. This section has also been amended to exempt replacement wells from the certification requirements. The exemption for emergency diversions has been amended to require that the person responsible for the emergency diversion notify the Department.

N.J.A.C. 7:20A-1.5, Schedule for applying for water usage certifications and establishing privileges to divert water, has been amended to require the registration of water diversions of less than 100,000 gallons per day.

N.J.A.C. 7:20A-1.6, Calculation of gallons of water per day used for agricultural or horticultural purposes; penalty provision, sets forth the means of calculating the gallons of water per day used for agricultural or horticultural purposes, and provides that the penalties contained in N.J.A.C. 7:14-8 apply to violations of this chapter.

N.J.A.C. 7:20A-1.7, Procedure after transfer of ownership or operation of agricultural or horticultural property with existing water usage certification, describes the procedure to be followed in transferring an existing water usage certification after transfer of ownership or operation of the property.

N.J.A.C. 7:20A-1.8, Complaints of interference, is a new section that provides a procedure for handling complaints of interference with a diversion source.

N.J.A.C. 7:20A-1.9, Program information, has been amended to reflect the Department's current name and address. This section has been recodified from N.J.A.C. 7:20A-1.8.

N.J.A.C. 7:20A-1.10, Severability, has been recodified from N.J.A.C. 7:20A-1.9.

N.J.A.C. 7:20A-2.1, Scope, sets forth the scope of the subchapter governing the water usage certification procedure.

N.J.A.C. 7:20A-2.2, Information and reports, has been amended to provide that annual water use reports will be due on February 28 of each year; this allows time for users to submit their reports after the close of the reporting period on December 31.

N.J.A.C. 7:20A-2.3, General application procedures, sets forth the procedures for applying for water usage certifications.

N.J.A.C. 7:20A-2.4, Standards and procedures for approval of water usage certifications, has been amended at N.J.A.C. 7:20A-2.4(a)4 to require the applicant to establish that the proposed groundwater withdrawal does not adversely affect other permitted users. N.J.A.C. 7:20A-2.4(a)6 has been modified to more accurately identify those areas in which the cone of depression will be considered to have an adverse impact. The same paragraph has been amended to require the applicant to establish that the diversion will not interfere with remediation activities.

N.J.A.C. 7:20A-2.5, Applications for renewal or modification of existing water usage certifications, sets forth the procedure for renewing and modifying certifications.

N.J.A.C. 7:20A-2.6, Preliminary application review, provides for the preliminary review of applications to determine completeness.

N.J.A.C. 7:20A-2.7, Extension of existing certifications, has been amended to include a one-time two-year extension of certifications which will expire in 1994 or 1995 if the diversion amount is less than 15.5 million gallons per month.

N.J.A.C. 7:20A-2.8, Opportunity to review application by interested parties, has been amended to include the requirement that diversion sources and their location be included in the public notice of the application for certification.

N.J.A.C. 7:20A-2.9, Verification of agricultural water need and determination of appropriate processing for application, has been amended to delete the requirement that certification applications for diversions of 500,000 or more gallons of water per day outside the Pinelands and for all certifications for diversions within the Pinelands be referred to the Department for review.

N.J.A.C. 7:20A-2.10, Applications referred to the Department, describes the procedure by which the county agricultural agent must refer certification applications to the Department.

N.J.A.C. 7:20A-2.11, Advisory Panel, has been amended to allow the Advisory Panel to make a recommendation for approval or disapproval of an application without using the public hearing process if an objection to the application is not related to the use of water or to impacts of the use of water.

N.J.A.C. 7:20A-2.12, Notice of public hearing requirements, has been amended to reduce the newspaper publication of the Public Hearing Notice from one day per week for two weeks to one time. This section has also been amended to require that the Department notify all certification holders and governing bodies of municipalities and counties within a one-mile radius of the proposed diversion about the public hearing.

N.J.A.C. 7:20A-2.13, Expenses of hearing, requires the applicant to pay all expenses of the public hearing.

N.J.A.C. 7:20A-2.14, Public hearing, describes the duties of the hearing officer who conducts the public hearing.

N.J.A.C. 7:20A-2.15, Public hearing report, has been amended to delete the opportunity for public comment on the hearing officer's report.

N.J.A.C. 7:20A-2.16, Decision maker's recommendation, establishes that it is the duty of the decision maker in the Department to make a final recommendation to the county agricultural agent regarding an application.

N.J.A.C. 7:20A-2.17, Notification of recommendation, describes how the Department shall notify the county agricultural agent of its recommendation.

N.J.A.C. 7:20A-2.18, Approval by county agricultural agent, has been amended to clarify that the recommendation of the Department is the final recommendation referenced in N.J.A.C. 7:20A-2.16. This section has also been amended to include among those to be notified of the decision on the application the people who have provided written comments on it.

N.J.A.C. 7:20A-2.19, Record of decision, provides that the Department shall maintain the record of the decision on each application reviewed.

N.J.A.C. 7:20A-2.20, Appeal procedure, establishes the procedure for appealing a decision on an application. The entire section has been rewritten to clarify the information needed from the party requesting the appeal. The current rule provides that the applicant, Department or other third party has right to a hearing if adversely affected by a decision on a water usage certification application. As amended, only an applicant has the right to request a hearing and the rule allows the Department to determine whether a request for a hearing is granted.

N.J.A.C. 7:20A-2.21, Validity of water usage certifications issued, describes the conditions that establish the validity of issued water usage certifications.

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N.J.A.C. 7:20A-2.22, Certification programs, establishes that a water usage certification may include the right to construct, repair or reconstruct dams and other related structures.

N.J.A.C. 7:20A-3.1, Scope, is a new section which sets forth the scope of the subchapter governing the water use registration procedure.

N.J.A.C. 7:20A-3.2, Information, is a new section which sets forth what information will be maintained by the Department and the county agricultural agent for each water use registration holder.

N.J.A.C. 7:20A-3.3, Procedure for obtaining an agricultural water use registration, is a new section that sets forth the procedure for obtaining an agricultural water use registration for diversions of less than 100,000 gallons per day for agricultural or horticultural purposes.

Social Impact

The readopted chapter will continue to have a positive effect on the people and agricultural community of the State by providing for better management of water resources and ensuring that there are safe and adequate water supplies for agricultural and horticultural purposes. These rules demonstrate the Department's determination to protect the State's water supplies and to provide the citizens of New Jersey with an ample and effectively managed water supply in accordance with the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.

The proposed amendments will enable the agricultural and horticultural community to more easily comply with the regulatory requirements while at the same time provide the Department with the information it needs to effectively manage New Jersey's water resources for the common good.

Economic Impact

The amendments and the readoption of the chapter will have a minor economic impact on those persons having the capability to divert 100,000 gallons of water per day for agricultural or horticultural purposes. Although there are no initial, annual or renewal fees associated with the registration or certification process, an applicant for a certification is required to pay for the public notice of the application as well as the costs of a public hearing, if held. Furthermore, new agricultural or horticultural water users seeking to obtain a registration or certification may need to employ professionals such as accountants, consultants, and irrigation specialists to assist in the application process.

The general public benefits economically because the implementation of these rules improves the quality of New Jersey's agricultural industry and protects property values and business interests.

Environmental Impact

The readoption of this chapter will have a positive effect on the environment because the rules ensure the proper management of the water resources in the State for agricultural and horticultural purposes. Proper management prevents depletion of aquifers and the spread of groundwater contamination and saltwater intrusion into aquifers, and helps preserve aquatic life.

Regulatory Flexibility Statement

This chapter applies to all persons having the capability to divert water at a rate of 100,000 gallons per day or greater for agricultural or horticultural purposes. It is estimated that, of the 1,200 persons affected by these rules, nearly 100 percent qualify as "small businesses" as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The small businesses already engaged in agricultural or horticultural activities will continue to have to comply with the provisions and requirements of the chapter, as described in the Summary above. The readoption of this chapter will not result in the need for any additional professional services by current users who already possess certifications. New agricultural or horticultural water users who need to obtain certification will incur some costs for the professional services of, for example, accountants and consultants.

Although there are no initial or annual fees associated with the certification process, an applicant is required to pay for the public notice of the application for a new and/or modified certification as well as the costs of the public hearing, if one is required. The cost of the public notice is approximately $50.00, and the stenographer's fee for the hearing record is approximately $250.00 (depending upon the length of the transcript). There is no public notice or hearing requirement for the registration program. In readopting these rules, the Department balanced the need to protect the water supply and the economic impact of the rules on small businesses, and determined that to minimize the economic impact of the rules on small businesses would endanger the environment, the public health and the public safety. Therefore, no exemption from coverage is provided.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 7:20A.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:20A-1.1 Scope and authority

This chapter shall constitute rules governing water usage certifications for agricultural and horticultural purposes pursuant to the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq. This chapter establishes the schedule **that** persons [diverting] **having the capability to divert** 100,000 or more gallons of water per day for agricultural or horticultural purposes shall follow to establish their privilege to divert water and prescribes the application, review, notification and hearing procedures for establishing privileges to divert water and to obtain water usage certifications **and/or registrations**.

7:20A-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Agricultural or horticultural purposes" means the commercial activity of producing principally for sale [food] crops, plants, animals or their products for the use or consumption by man including in a primary sense the growing, harvesting, storage and the on-farm preparation for use and marketing of [food] crops, plants, animals or their products.

"Agricultural water use registration" or "water use registration" means the document submitted to and processed by the county agricultural agent by persons having the capability to divert more than 100,000 gallons of water per day but using less than said quantity for agricultural or horticultural purposes.

"Applicant" means any person filing or required to file an application [to establish a privilege to divert water or] for a water usage certification **or water use registration to establish a privilege to divert water** pursuant to this chapter or the Act. An applicant may be the owner or operator of property or a person leasing property for agricultural or horticultural purposes.

["Appropriate county agricultural agent" means the county agricultural agent assigned jurisdiction over the areas involved in the application.]

. . .

"Commissioner" means the Commissioner of the Department of Environmental Protection **and Energy** or his **or her** designated representative.

. . .

"County agricultural agent" **or "appropriate county agricultural agent" or "agent"** means [such person] **the faculty member** so designated by the [New Jersey Cooperative Extension Service] **Rutgers Cooperative Extension at the New Jersey Agricultural Experiment Station** in each of the respective counties.

["Critical aquifer" means an aquifer within a critical water supply area where there may be either insufficient water supply, shortage of ground water by overdraft, threat of salt water intrusion or contamination, or where circumstances existed which required the Department to impose special water supply management provisions by rule pursuant to N.J.A.C. 7:19-6.10.

"Critical water supply area" means any areas to be designated in which special water supply usage conditions shall be mandated pursuant to rules promulgated by the Department pursuant to Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.

"Critical water supply usage area" means any areas to be designated in which special water supply usage conditions shall be mandated pursuant to regulations promulgated by the Department pursuant to Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.]

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"Decision maker" means the person designated by the [Division] **Department** to make recommendations to the appropriate county agricultural agent on applications for water usage certifications and claims of privileges to divert water.

"Department" means the New Jersey Department of Environmental Protection **and Energy**.

. . .

["Division" means the Division of Water Resources in the Department of Environmental Protection.]

"Modification" means a change to a certification including, but not limited to, [requests for] an increase in certification amount, the addition of a new source, or [a change in agricultural/horticultural activity] **an increase in pump capacity of an existing source**.

. . .

["Pinelands area" means the area so designated by N.J.S.A. 13:18A-11(a) of the Pinelands Protection Act, N.J.S.A. 13:18A-1 et seq.]

"Replacement well" means a new well that is to replace an existing well which will be sealed in accordance with N.J.A.C. 7:9-9 and where the proposed well will be approximately the same depth as the existing well and diverting from the same aquifer; have the same or lesser pump capacity; and be within 100 feet of the existing well.

. . .

"Water supply allocation permit" means the permit issued by the Department to a person granting that person the privilege, so long as the person complies with the conditions of the permit, to divert 100,000 or more gallons of water per day for any purpose other than agricultural or horticultural purposes.

"Water supply critical aquifer" means an aquifer within a water supply critical area where there may be either insufficient water supply, shortage of groundwater by overdraft, threat of saltwater intrusion or contamination, or where other circumstances exist requiring the Department to impose special water supply management provisions by rule under N.J.A.C. 7:19-6.10.

"Water supply critical area" or "critical area" means a water supply area in which it is determined by the Department, after public notice and a public hearing, that adverse conditions exist, related to the ground or surface water, which require special measures in order to achieve the objectives of the Act.

. . .

7:20A-1.4 Applicability

(a) This chapter applies to all persons who have been issued a water usage certification, or to other persons **who are** diverting, **have the ability to divert** or claim[ing] the right to divert 100,000 or more gallons of water per day for agricultural or horticultural purposes, and to all persons who in the future wish to divert 100,000 or more gallons of water per day for agricultural or horticultural purposes except as specified below:

1. This chapter [shall] **does** not apply to [diversion of] **persons who divert** salt water [as determined by the Division] except [in situations such that] **where the Department determines that** salt water diversion and usage may affect **the** utilization of fresh water.

2. (No change.)

[3. This chapter shall not apply in cases of emergency as defined in State contingency plans; fire fighting; flood prevention; or any other emergency diversion of water. If such an emergency diversion is contemplated to continue for a period of more than three months, then a certification shall be applied for within 30 days of the beginning of the emergency or of the determination that the emergency will last for more than three months, whichever is less, in accordance with this chapter.]

3. This chapter does not apply to persons who make emergency diversions of water for periods of less than 31 days. An emergency diversion includes the taking of water for the purpose of fire fighting, flood prevention, hazardous substance and/or waste spill response, or for other emergency purposes as determined by the Department. In all cases of emergency diversion, the person responsible for the diversion shall contact the Department within 48 hours of initiation of the emergency diversion. If the emergency diversion is expected to continue for 31 days or more, then the person initiating the emergency diversion shall apply for a water supply allocation permit or water usage certification, as appropriate, within 30 days after initiating the emergency diversion.

4. (No change.)

5. An application for a modification of a water usage certification, as provided for under N.J.A.C. 7:20-2.5(b), is not required for the installation of a replacement well included in an existing water usage certification.

i. Prior to the installation of the replacement well, the holder of the existing water usage certification shall provide the following information to the appropriate county agricultural agent for the replacement well and the existing well:

(1) Location;

(2) Pump capacity and depth; and

(3) Well permit number and local name or number.

ii. The holder of the water usage certification shall submit a copy of the well abandonment report for the existing well to the county agricultural agent within 30 days of installation of the replacement well. The existing well shall be sealed in accordance with N.J.A.C. 7:9-9.

iii. The county agricultural agent shall submit to the Department the informationn required under (a)5i and ii above within 60 days after the installation of the replacement well.

7:20A-1.5 Schedule for applying for water usage certifications and establishing privileges to divert water

(a) (No change.)

(b) Any person who intends to divert less than 100,000 gallons of water per day for agricultural or horticultural purposes, but who has the capability to divert 100,000 gallons of water per day or more, shall register the diversion source in accordance with the procedures set forth in N.J.A.C. 7:20A-3.3.

7:20A-1.8 Complaints of interference

(a) The appropriate county agricultural agent shall refer to the Department all complaints received from persons alleging that their diversion source is being adversely impacted by an existing diversion source which is included within a water usage certification.

(b) All complaints shall be made in writing and shall include:

1. The location of the involved wells or intakes;

2. The nature and frequency of interference; and

3. The well drilling permit number, well depth and capacity for each of the complainant's wells.

(c) The Department shall investigate and determine the validity of all such complaints.

7:20A-[1.8]**1.9** Program information

Unless otherwise specified, any questions concerning the requirements of N.J.A.C. 7:20A-1 and 2 shall be directed to the appropriate county agricultural agent, or to the Bureau of Water Allocation, Water Supply Element, [Division of Water Resources], New Jersey Department of Environmental Protection **and Energy**, CN [029] **426**, Trenton, New Jersey 08625.

7:20A-[1.9]**1.10** (No change in text.)

7:20A-2.2 Information and reports

(a) The [Division] **Department and the appropriate county agriculture agent** shall maintain a record of all existing **water usage** certifications for agricultural or horticultural purposes.

(b) The record required pursuant to (a) above shall include the following information:

1. (No change.)

2. Amount of water [previously] permitted to be diverted;

3. (No change.)

4. Whether location of the existing certification is within a [critical water supply area] **water supply critical area**; and

5. Other information deemed necessary by the [Division] **Department.**

(c) Copies of the existing certification documents will be provided to the appropriate county agricultural agent upon a [written] request to the [Division] **Department.**

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(d) The appropriate county agricultural agent shall concurrently upon issuance of any water usage certification issued pursuant to this chapter provide the Bureau of Water Allocation of the [Division] **Department** with a copy of the [relevant] water usage certification.

(e) The appropriate county agricultural agent shall include as standard conditions in all water usage certifications issued pursuant to this chapter the following information to be annually prepared and submitted to the appropriate county agricultural agent:

1. An accounting of monthly water usage [on December 31 of each year] **for each calendar year by February 28 of the following year**; and

2. (No change.)

7:20A-2.4 Standards and procedures for approval of water usage certifications

(a) In general, an applicant for a water usage certification shall provide all information reasonably available [to the applicant] which establishes that the application complies with the standards and procedures as follows:

1.-3. (No change.)

4. The plans for the proposed diversion are just and equitable to the other known water users affected thereby**, and the withdrawal from the aquifer does not adversely affect other permitted withdrawals.**[; such] **Such** known water users shall be identified and located on [an appropriate map] **a United States Geological Survey Quadrangle Map**; and

5. [In the case of surface water only, whether the reduction of the dry season flow of any stream will be caused to an amount likely to produce unsanitary] **The proposed diversion will not reduce the dry season flow of any stream so as to adversely affect sanitary** conditions downstream or otherwise unduly injure public or private interests; or

6. In the case of groundwater only, [that] the proposed diversion does not lie within a cone of depression **where the aquifer to be utilized is overstressed or threatened by saline intrusion,** [and that] the location **of the proposed diversion** relative to hazardous waste disposal sites or other major sources of pollution is not [such as to be] likely to [result in] **cause or spread** groundwater contamination**, and the diversion will not interfere with any groundwater contamination clean-up plans or activity**.

(b) Applications for renewal of existing certifications shall supply information not previously established in the existing certification, any information relevant to proposed changes in certification conditions, and other information as requested by the appropriate county agricultural agent or the [Division] **Department** for the proper implementation of the Act and this chapter.

(c) The appropriate county agricultural agent shall review the application and make a determination concerning the accuracy of information submitted pursuant to (a) and (b) above, and based on the appropriate county agricultural agent's actual knowledge of the [water systems] **agriculture and horticulture** in the area of the [application] **proposed diversion**.

(d) If based upon the appropriate county agricultural agent's actual knowledge, the information submitted is insufficient to indicate compliance with (a) and (b) above, the appropriate agricultural agent **in consultation with the Department** shall request additional information or consideration [of] **by** the applicant of some more suitable alternative source of water.

7:20A-2.7 Extension of existing certification: privileges allowed pursuant to other lawful legislative or administrative actions by county agricultural agent

(a) (No change.)

(b) If an application requests an extension of the existing certification or privileges previously allowed pursuant to other lawful legislative or administrative actions under the same conditions as previously allowed and the applicant does not request an increase in the amount of water diverted or any modification of the existing certification, the appropriate county agricultural agent may directly issue a new five year certification under the previous conditions plus any additional conditions deemed necessary by the appropriate county agricultural agent or the [Division] **Department** without public notice as set forth in N.J.A.C. 7:20A-2.8(b) below.

(c) N.J.A.C. 7:20A-2.7(a) and (b) shall not apply to diversions located within any designated [critical water supply area] **water supply critical area**.

(d) Any certification which has an approved diversion amount of less than 15.5 million gallons per month and which expires in 1994 or 1995 is extended for a period of two years to 1996 or 1997, respectively.

7:20A-2.8 Opportunity to review application by interested parties

(a) (No change.)

(b) The applicant, [in coordination] **with assistance from** the county agricultural agent, shall have a notice of the application published in a newspaper circulating in the [territory] **area** affected by the application within 30 days of the application being deemed complete. A notice is not required for a renewal without modification.

1. The notice shall be published for one day per week for two weeks and shall summarize the application**, including the diversion sources and location** [and describe the area affected].

2. (No change.)

7:20A-2.9 Verification of agricultural water need and determination of appropriate processing for application

(a) The county agricultural agent shall verify the need for the water usage requested for [all] **any** application[s] submitted and make a determination whether the application[s] for a water usage certification describes and includes **the** proposed diversion as follows:

1. Within a **water supply** critical aquifer in [critical water supply areas] **a water supply critical area; or**

2. When objections have been filed concerning an application with the appropriate county agricultural agent[;].

[3. Within the pinelands area; or

4. Outside the pinelands area for diversions of not more than 500,000 gallons as calculated pursuant to N.J.A.C. 7:20A-1.6(a).]

(b) If the application for a water usage certification concerns (a)1 **or 2** above, the application shall be processed pursuant to N.J.A.C. 7:20A-2.8 and 2.10.

[(c) If the application for a water usage certification concerns (a)2 above, the application shall be processed pursuant to N.J.A.C. 7:20A-2.8 and 2.10.]

[(d)**(c)** [Unless specified in] **An application not governed by** (a)1 or 2 above, **or** [if the] **an** application [for a water usage certification concerns either (a)3 or 4 above or is] for renewal of an existing **water usage** certification[, the application] may be directly approved or disapproved by the appropriate county agricultural agent without any further processing, [and] pursuant to the standards and procedures for approval of certifications set forth at N.J.A.C. 7:20A-2.4[, including] **and subject to the public notice provisions of N.J.A.C. 7:20A-2.8, and shall include** conditions deemed necessary by the appropriate county agricultural agent or the [Division,] **Department** [and subject to the public notice provisions of N.J.A.C. 7:20A-2.8].

[(e)]**(d)** All other applications for a water usage certification not [specified in N.J.A.C. 7:20A-2.9] **governed by this section** shall be processed pursuant to N.J.A.C. 7:20A-2.8 and 2.10.

7:20A-2.10 Applications referred to the [Division] **Department**

(a) The appropriate county agricultural agent shall forward verification of [the] **an** applicant's need for **the** water usage requested and the following information to the Bureau of Water Allocation [of] **in** the [Division] **Department** for [all] **any** application[s pursuant to] **governed by** N.J.A.C. 7:20A-2.9(b), [(c) and (e)] **and (d)** above:

1. The county agricultural agent shall also promptly forward to the [Division] **Department** copies of any written objections to the [proposed] application from any interested parties.

2. The appropriate county agricultural agent shall forward the application and all other relevant data to the [Division's] **Depart-**

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ment's Bureau of Water Allocation for evaluation and review of the application's compliance with the standards and procedures set forth in N.J.A.C. 7:20A-2.4.

(b) The [Division's] **Department's** Bureau of Water Allocation shall review and evaluate the application and verification of the need for the water usage and complete the following activities:

1. Enter information concerning the application into official [Division] **Department** records;

2.-5. (No change.)

(c) If no written objection from any interested parties concerning the application for a water usage certification has been [made or] received by the county agricultural agent and no written objections are made during the [Division's] **Department's** Bureau of Water Allocation review process, and the application complies with the standards and procedures set forth in this chapter, then the [Division's] **Department's** Bureau of Water Allocation shall:

1. Draft the necessary water usage certification[s with attachments of], **including** any conditions [deemed] **it deems** necessary, and obtain approval of the [Division's] **Department's** designated decision maker; and

2. Recommend that the appropriate county agricultural agent issue the water usage certification drafted by the [Division's] **Department's** Bureau of Water Allocation and based upon the standards and procedures set forth in this chapter.

(d) (No change.)

7:20A-2.11 Advisory Panel

(a) If objections are made concerning an application for a water usage certification by the [Division] **Department** or any interested parties, then the appropriate county agricultural agent shall convene an informal Advisory Panel which shall consist of the designated representative of the Commissioner of the Department of Environmental Protection **and Energy**, the designated representative of the Secretary of Agriculture, and the designated representative of the Dean of Cook College. The Advisory Panel shall have the following duties:

1. Schedule an informal meeting with the applicant, the [Division] **Department**, the appropriate county agricultural agent, and interested parties who have [registered official] **submitted** written objections to the application **to the agricultural agent or the Department**.

2. (No change.)

3. If an agreement satisfactory to all parties can be made through the good offices of the Advisory Panel, the Advisory Panel shall prepare a [written document] **report** outling the suggested settlement to the [Division] **Department**, [for recommendation for] **recommending** approval [or denial] of the suggested settlement by the appropriate county agricultural agent.

i. The appropriate county agricultural agent may then issue a water usage certification, drafted by the [Division] **Department**, based upon the recommendation[s] of the Advisory Panel **and** including any other conditions deemed necessary by the [Division] **Department**.

4. If the Advisory Panel determines that the objections concerning an application for a water usage certification are without merit or frivolous in nature **or are not related to the use of water or the impacts of the use of water**, the Advisory Panel shall include in its [written recommendation] **report** that the application for a water usage certification be approved or disapproved without utilization of the public hearing process set forth at N.J.A.C. 7:20A-2.12. If the [Division] **Department** concurs with this recommendation of the Advisory Panel, the [Division] **Department** shall recommend that the appropriate county agricultural agent issue either a water usage certification, drafted by the [Division] **Department**, or a letter of denial for the application for a water usage certification. All persons presenting objections before the Advisory Panel shall receive **from the county agricultural agent** a copy of either the water usage certification or the letter of denial for the purposes of future actions pursuant to N.J.A.C. 7:20A-2.20.

(b) If no resolution can be achieved by the Advisory Panel or if the Advisory Panel determines that the objections have merit and are not frivolous in nature pursuant to [N.J.A.C. 7:20A-11(a)4] **(a)4 above**, then the public hearing process outlined in this subchapter shall be followed.

7:20A-2.12 Notice of public hearing requirements

(a) When a public hearing on a water usage certification is required pursuant to N.J.A.C. 7:20A-2.11(b), or the appropriate county agricultural agent or the [Division] **Department** determines that a public hearing is required in the public interest, the [Division] **Department** shall:

1. (No change.)

2. Have a notice of the public hearing published one [day per week for two weeks] **time** in a newspaper circulating in the [territory] **area** affected by the application at least 30 days prior to the scheduled hearing.

i. If the [Division] **Department** determines that an emergency or other similar circumstance[s] requires an expedited hearing, the notice of the hearing need only be published in a local newspaper at least 14 days prior to the scheduled hearing.

3. Notify, in writing, the applicant, the governing bodies of municipalities and counties [in the territory affected by the application,] **and the water supply allocation permit and water usage certification holders within a one-mile radius of the diversion,** and **the** officials of existing public water systems within a five-mile radius of the proposed diversion [and all Water Allocation permit holders within a one mile radius].

(b) (No change.)

(c) The public hearing shall be before a hearing officer [specified] **designated** by the [Division] **Department**.

(d) Between the time the notice is published and the scheduled date for the public hearing, the [Division] **Department** shall review the application and develop staff recommendations concerning the disposition of the application and any conditions that should be included in the water usage certification if issued.

1. The staff recommendations shall include and consider the application, the water usage verification [of] **by** the appropriate county agricultural agent, the Advisory Panel's report, written comments of interested parties, and all other relevant information pertaining to the application. These staff recommendations shall be:

i.-ii. (No change.)

iii. If there is no hearing, upon timely written request by the applicant or any interested person to the [Division] **Department**, the staff recommendations shall be made available to the applicant or any interested person within seven days of the rendering of a decision **to approve or deny the application**.

7:20A-2.13 Expenses of hearing

The cost of advertisement and other expenses of the hearing, including stenographic record, but excluding expenses for [Division] **Department** hearing staff, will be certified to the applicant who shall pay the bill within 30 days thereafter. Payment in full of the bill shall be a condition of final water usage certification issuance.

7:20A-2.14 Public hearing

(a) The hearing officer shall have reasonable discretion in the conduct of the public hearing and shall give:

1. The applicant opportunity to submit his **or her** information [meeting] **to meet** the requirements of this chapter;

2. Other persons opportunity to comment in favor of or in opposition [to matters relevant] to the application; and

3. The applicant opportunity to respond to the [commenters] **comments,** including written comments received by the [Division] **Department**.

(b) The hearing officer shall give the applicant reasonable time after the hearing to correct deficiencies in [its] **the** application and respond to comments received at the hearing.

7:20A-2.15 Public hearing report

(a) The hearing officer shall review the application, the water usage verification [of] **by** the appropriate county agricultural agent, the [Division's] **Department's** Bureau of Water Allocation recommendation, the Advisory Panel's report, written comments of interested parties, **the** transcripts from the public hearing, and all other

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relevant information pertaining to the application, and **shall** prepare and submit written findings and recommendations to the decision maker for a final recommendation for approval or disapproval of the application for a water usage certification by the appropriate county agricultural agent.

[1. These findings and recommendations shall be made available and an opportunity for comment offered to the applicant and other principal interested parties.]

7:20A-2.18 Approval by county agricultural agent

(a) The appropriate county agricultural agent shall approve or disapprove of water usage certification applications in accordance with the [binding] **final** recommendations of the Department as provided in this chapter.

(b) (No change.)

(c) In addition, **the county agricultural agent shall notify by letter** all persons testifying at the public hearing **or who have provided written comments** [shall be notified by letter] of the decision of the appropriate county agricultural agent.

7:20A-2.19 Record of decision

(a) There shall be maintained by the [Division] **Department** for each application reviewed a record consisting of copies of:

1.-8. (No change.)

(b) This record may be reviewed by interested parties at the [Division] **Department** and copies of it may be obtained [from the Division] upon payment of the fee for duplication.

7:20A-2.20 Appeal procedure

[(a) The applicant, the Department or any person alleging to be adversely affected by the decision on a water usage certification application shall have a right to a hearing thereon if requested in writing within 20 days of receipt of a copy of the decision. The request for a hearing shall be sent to the Office of Legal Affairs, ATTENTION: Adjudicatory Hearing Requests, Deparment of Environmental Protection and Energy, CN 402, Trenton, New Jersey 08625-0402. Any person or entity alleging to be adversely affected by the decision on a water usage certification shall be required to specify in writing and in detail the basis for its appeal.

(b) For 30 days following receipt of the request for a hearing, the appropriate county agricultural agent and the Division shall attempt to settle the dispute by conducting such proceedings, meetings and conferences as deemed appropriate.

(c) If such efforts at settlement fail, the Department shall file the request for a hearing with the Office of Administrative Law provided the conditions of (a) above have been satisfied by the person or entity alleging to be adversely affected by the decision on a water usage certification.

(d) The hearing shall be held before an administrative law judge and in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., as amended and supplemented, and the Office of Administrative Law's Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(e) The decision by the Commissioner, based on the record of the application and the recommendations of the administrative law judge shall be the final administrative decision on the approval/or denial of the application.]

(a) An applicant who believes himself or herself to be aggrieved by a decision of the Department regarding any water usage certification may contest the decision and request a contested case hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the New Jersey Uniform Administrative Procedure Rules, N.J.A.C. 1:1, if the Department:

1. Approves or denies an application for a water usage certification, or any part thereof; or

2. Revokes, withdraws or modifies a previously issued approval.

(b) Requests for a contested case hearing shall be submitted to:

Office of Legal Affairs
Attn: Adjudicatory Hearing Requests
Department of Environmental Protection and Energy
CN 402
401 East State Street
Trenton, New Jersey 08625-0402

(c) All requests for a contested case hearing shall be submitted to the Department within 20 calendar days after the date upon which the applicant received the notice of Department's decision.

(d) All requests for a contested case hearing shall be submitted in writing to the Department and shall contain:

1. The name, address and telephone number of the person making the request;

2. A statement of the legal authority and jurisdiction under which the request for a hearing is made;

3. A brief and clear statement of specific facts describing the Department decision being appealed, as well as the nature and scope of the interest of the requester in the decision; and

4. A statement of all facts alleged to be at issue and their relevance to the Department decision for which a hearing is requested, as well as any legal issues associated with the alleged facts at issue.

(e) A hearing request not submitted within 20 days after the applicant received notice of Department's decision shall be denied by the Department.

(f) If the applicant fails to include any of the information required under (d) above, the Department may deny the hearing request.

(g) The Department will determine whether any request for a contested case hearing shall be granted. In making such determination, the Department will evaluate the request to determine whether a contested case exists and whether there are issues of fact which, if assumed to be true, might change the Department's decision. Where only issues of law are raised in a request for a hearing, the request will be denied. Denial by the Department of a request for a contested case hearing shall constitute the final decision of the Department for the purposes of judicial appeal.

(h) The hearing, if granted, shall be held before an administrative law judge and in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the rules promulgated thereunder.

SUBCHAPTER 3. WATER USE REGISTRATION PROCEDURE

7:20A-3.1 Scope

This subchapter prescribes the procedures which shall be followed by applicants, county agricultural agents, and the Department when applying for and in the processing of applications for water use registrations.

7:20A-3.2 Information

(a) The Department and the appropriate county agricultural agent shall maintain a record of all water use registrations for agricultural or horticultural purposes.

(b) The record required pursuant to (a) above shall include the following information:

1. The name and address of existing registration holders;

2. The diversion source and location; and

3. Other information deemed necessary by the Department.

(c) Copies of the existing water use registration documents will be provided to the appropriate county agricultural agent upon a request to the Department.

7:20A-3.3 Procedure for obtaining an agricultural water use registration

(a) The Department will provide the current application form for agricultural water use registrations to all county agricultural agents.

(b) An applicant for a water use registration for the diversion of less than 100,000 gallons of water per day for agricultural or horticultural purposes shall contact the appropriate county agricultural agent to obtain an application form and other instructions needed to file a complete application.

(c) Any person who presently has the capability to divert 100,000 or more gallons of water per day, but who diverts less than that quantity for agricultural or horticultural purposes, shall apply for a water use registration within 180 days of the adoption of these rules.

(d) The applicant shall follow all the instructions to complete the application form, and shall submit the completed application form to the appropriate county agricultural agent.

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1. The following items will be required as part of the application form:

i. The name and address of applicant;

ii. The type and a description of each diversion source;

iii. The location of each diversion source; and

iv. The maximum quantity of water to be diverted from each source on a monthly basis.

(e) A water use registration number shall be assigned to the applicant by the county agricultural agent, upon his or her determination that the water needs are less than 100,000 gallons of water per day.

(f) The county agricultural agent shall forward to the Department a copy of the water use registration when approved.

(a)

AIR QUALITY REGULATION PROGRAM

Air Pollution Control
Operating Permits

Proposed New Rules: N.J.A.C. 7:27-22
Proposed Amendments: N.J.A.C. 7:27-1, 8 and 18

Authorized By: Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1B-3, 13:1D-9 and 26:2C-1 et seq.

DEPE Docket Number: 46-93-08/156.

Proposal Number: PRN 1993-502.

A **public hearing** concerning this proposal will be held on:

Tuesday, October 12, 1993, at 10:00 A.M.
New Jersey Department of Environmental Protection and Energy
Hearing Room, 1st floor
401 East State Street
Trenton, New Jersey 08625

Submit written comments, identified by the Docket Number given above, by October 27, 1993, to:

Janis Hoagland, Administrative Practice Officer
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

Copies of the proposed new rule will be available for inspection during normal office hours until October 27, 1993, at:

Atlantic County Health Department
201 South Shore Road
Northfield, New Jersey 08225

Middlesex County Air Pollution Control Program
County Annex Building
841 Georges Road
North Brunswick, New Jesey 08902

Warren County Health Department
319 West Washington Avenue
Washington, New Jersey 07882

New Jersey Department of Environmental Protection and Energy
Office of Energy
401 East State Street, Seventh Floor
Trenton, New Jersey 08625

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Northern Regional Office
1259 Route 46, Bldg. No. 2
Parsippany, New Jersey 07054

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Southern Regional Office
20 East Clementon Road, 3rd Floor North
Gibbsboro, New Jersey 08026

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Metropolitan Regional Office
2 Babcock Place
West Orange, New Jersey 07052

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Central Regional Office
Horizon Center, Building 300
Route 130
Robbinsville, New Jersey 08691

The new rule and amendments will become operative either 60 days after their adoption or on July 1, 1994, whichever is later.

The agency proposal follows:

Summary

Overview

The New Jersey Department of Environmental Protection and Energy (the Department) is proposing new rules at N.J.A.C. 7:27-22 (subchapter 22), establishing an air pollution control operating permit program for major sources of air contaminant emissions. The Department is proposing related amendments to N.J.A.C. 7:27-1, 8 and 18. In two related proposals published in this issue of the New Jersey Register, the Department is also proposing amendments to N.J.A.C. 7:27A and N.J.A.C. 7:27-21.

Currently, the Department primarily controls air pollution at stationary sources of air contaminant emissions through the issuance of preconstruction permits, which are required before air contaminant emitting equipment may be installed or altered, and operating certificates, which authorize the operation of the equipment once it is built. These permits and certificates are issued pursuant to N.J.A.C. 7:27-8 (subchapter 8).

In accordance with the 1990 amendments to the Federal Clean Air Act (CAA), the Department must now adopt a new operating permit program. In an effort to consolidate the existing preconstruction permit program with the proposed operating permit program, substantial revisions to the preconstruction program set forth at subchapter 8 are also being proposed.

In addition to the revisions made to N.J.A.C. 7:27-8, relatively minor amendments are proposed to N.J.A.C. 7:27-1 and 18 to make these subchapters consistent with the proposed operating permit program at N.J.A.C. 7:27-22. Changes are also being proposed, through a separate rule proposal published in this issue of the New Jersey Register, to N.J.A.C. 7:27-27A, the Department's penalty rules, to provide for penalties for violations of the proposed new subchapter 22, and for violations of rule provisions regarding the use of continuous monitoring systems (CMS).

The proposed new rules and amendments are in response to the requirements of the Federal Clean Air Act, 42 U.S.C. §7401 et seq. (the CAA) as amended by the Clean Air Act Amendments of 1990, P.L. 101-549, November 15, 1990. Pursuant to Title V of the CAA, 42 U.S.C. 7661 to 7661f, the United States Environmental Protection Agency (EPA) has promulgated regulations at 40 CFR 70 (Part 70), that specify the minimum required elements of State operating permit programs. These regulations were published in the July 21, 1992 Federal Register at volume 57, page 32250, 57 FR 32250 (1992). The CAA requires every State to develop, and to submit to EPA for approval, programs for issuing operating permits to certain stationary sources of air contaminant emissions. The State programs must be at least as stringent as the Federal requirements. The State's proposed operating permit program, including adopted rules, is due to the EPA by November 15, 1993. If the Department fails to implement the program within the time allowed by the CAA, the State will be subject to severe Federal sanctions, including the loss of New Jersey's Federal highway funds.

Public Involvement in the Rulemaking Process

In an effort to provide an open dialogue with the environmental and regulated communities and other interested persons, the Department began an interactive process early in the development of the operating permit program. Formal training seminars and informal workshops were held for the public at large and, in many instances, the Department gave presentations tailored for various groups which will be affected by the

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proposed new rules and amendments. Written material such as descriptions of Federal rules, state program plans and charts and graphs were distributed. These materials were also made available by mail and at Department presentations.

The Department held an initial workshop on the CAA requirements in October 1991, to which the public, including representatives of the regulated and environmental communities, were invited. This initial workshop included a discussion on the overall requirements of EPA's operating permit rule. (EPA's rule was at that time proposed, but had not yet been finally adopted). The Department solicited comments from the public on how best to implement the operating permit program in New Jersey. Two workgroups were formed to focus on the operating permit program, a de minimis emissions workgroup and a modelling and risk assessment workgroup. Each workgroup met at least four times to discuss program implementation issues. As a result of these early meetings, the Department has included several provisions in the proposed rule, including provisions concerning de minimis emissions operational flexibility, intra-facility emissions trading, and streamlined air quality evaluation procedures.

The Department has also had numerous meetings with three groups known as the Industrial Advisory Group (IAG), the IAG Operating Permit Workgroup and a Utilities Workgroup. These ad hoc groups have provided ongoing input to the Department on various environmental issues over several years. In the case of the subchapter 22 program, they provided valuable input on the general implementation of the operating permit program, as well as suggestions for the development of application forms and model permits.

Over the last several years the Department has worked closely with the regional air pollution control associations to which it belongs, participating in several operating permit program development committees and sharing information. These associations include the Northeast States for Coordinated Air Use Management (NESCAUM), the MidAtlantic Region Air Management Association (MARAMA) and the Ozone Transport Commission (OTC). The Department has also worked with the State and Territorial Air Pollution Program Administration (STAPPA) and the Association of Local Air Pollution Control Officials (ALAPCO) on operating permit program development guidance.

The Department has presented, as part of the Air Quality Regulation program's regular Air Permit Workshops, two one-day seminars on the operating permit program requirements. Over 150 people from the environmental and regulated communities attended each workshop. Also, approximately 30 to 40 presentations and seminars concerning operating permits plans were conducted by Department representatives for interested groups.

Operative Dates

Subchapter 22, Operating Permits, along with revisions to N.J.A.C. 7:27-8, (subchapter 8) Permits and Certificates, and changes to subchapters 1 and 18, are proposed to become operative July 1, 1994. The first annual operating permit fees would be due September 30, 1994. The requirement for maximum achievable control technology for new or altered sources of hazardous air pollutants would be effective upon EPA's approval of the operating permit program. The first group of initial operating permit applications would be due to be submitted to the Department on November 15, 1994, with other groups of applications due at six month intervals thereafter. Operating permits would be reviewed and issued between November 15, 1994 and November 15, 1999. Permits are issued within 18 months after submittal of an application, after undergoing public and EPA review and comment. For facilities subject to the proposed operating permit rule, the current subchapter 8 operating certificate fees would be replaced effective July 1, 1994 by fees due under the proposed rule.

Consolidation of Air Pollution Control Permit Programs

About 900 major air contaminant emitting facilities in New Jersey will be covered by the comprehensive, facility-wide operating permits. Smaller facilities will continue to be covered by equipment-specific operating certificates issued pursuant to subchapter 8 for new or altered source operations.

Owners or operators of facilities subject to operating permits must, in addition to obtaining an operating permit, maintain their existing preconstruction permits and obtain preconstruction permits for the installation of any new or altered equipment or control apparatus pursuant to N.J.A.C. 7:27-8. The operating permit will cover all source operations at the facility and will replace the existing operating certificates for individual pieces of equipment. Minor facilities not required to obtain an operating permit must continue to maintain their existing preconstruction permits and operating certificates. For the installation of new or altered equipment, minor facilities must continue to obtain new preconstruction permits and certificates to operate, pursuant to N.J.A.C. 7:27-8.

During the October 1992 workshop on implementing the 1990 amendments to the CAA, participants attending the operating permits segment of the workshop recommended that the existing preconstruction permit/operating certificate program (set forth at N.J.A.C. 7:27-8, also known as subchapter 8) and the new operating permit program should be consolidated. In response to those recommendations, the Department is proposing a coordinated permitting process, including a combined permit modification process for facilities subject to both subchapter 8 and the new operating permit program. If the owner or operator of a facility with an operating permit wishes to make a change which requires a preconstruction permit under subchapter 8 and a modification to the operating permit under the proposed new subchapter 22, the owner or operator will be able to file a single application to obtain both the preconstruction permit approval and the modification of the operating permit, thus saving both the applicant and the Department significant resources.

Operating Flexibility

The most significant changes proposed to the preconstruction permit program are to promote consistency with the operational flexibility provisions of the operating permit program. These changes include: an exemption for very low emissions from reporting requirements on permit applications (de minimis emissions), intra-facility emissions trading and provisions for permit changes upon seven days prior notice to the Department. These changes are discussed below:

1. De minimis Emissions—The de minimis emissions concept relates to the issue of what air contaminants must be specified in an application for a permit. Currently, any air contaminant emission, no matter how small, that is emitted by a source which is subject to regulation under subchapter 8, must be included in the preconstruction permit. The proposed new rules establish threshold "de minimis" levels for specific air contaminants. Because emissions below these levels are inconsequential from a public health and overall air pollution control perspective, emissions below the defined de minimis levels do not need to be included in the preconstruction permit or the operating permit application. Please see the discussion of N.J.A.C. 7:27-22.6 in this Summary for additional details.

2. Intra-facility Emissions Trading—The addition of intra-facility emissions trading allows a facility to propose an emissions cap for a group of source operations at a facility covered by an operating permit. This trading allows a facility to trade emissions between source operations in the specified group, as long as emissions do not exceed the cap or any applicable requirement. EPA's operating permit rule (Part 70.) requires that the permit must specifically state which source operations are included in an emissions cap. In addition, all emissions traded must be quantifiable and enforceable. To be quantifiable and enforceable, some form of periodic emissions measurement or continuous monitoring will be required. The operating permit must also include recordkeeping and reporting appropriate for emissions trading requirements. The primary benefit of an emissions cap is to allow a permittee to voluntarily cap its emissions and to therefore avoid regulatory provisions, such as prevention of significant deterioration (PSD) requirements and emission offsets, that would otherwise be triggered. The discussion of N.J.A.C. 7:27-22.28 below further describes intra-facility emissions trading.

3. Seven-day-notices—This proposal provides streamlined procedures to expeditiously address certain permit changes. One such procedure is the use of a seven-day-notice. The seven-day-notice allows certain changes which do not increase emissions to be made at a facility after merely filing a notice with the Department seven days prior to making the change. The seven-day-notice is also proposed to be added in N.J.A.C. 7:27-8.15 to allow certain changes to preconstruction permits, so that the same types of changes eligible for processing as a seven-day-notice change to an operating permit are also eligible for a seven-day-notice change to a preconstruction permit. For those facilities that are not subject to an operating permit, the seven-day notice can be used for the preconstruction permit and the operating certificate. A single seven-day-notice would be required to cover changes to both the preconstruction permit and the operating permit (or operating certificate). For a further explanation, and a list of changes eligible for processing as seven-day-notice changes, please see the summary of N.J.A.C. 7:27-22.22 and of N.J.A.C. 7:27-8.15.

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4. Alternative Operating Scenarios—EPA's Part 70 rule allows the State to incorporate alternative operating scenario provisions to provide additional operational flexibility. This allows a facility to identify, in the permit application, multiple operating scenarios for the use of equipment or control apparatus. Once approved by the Department in the permit, the facility may then switch from one operating scenario to another without notification to the Department. The Department currently implements this concept in the preconstruction permits program. The proposed rules will expand its use to operating permits. The discussion of N.J.A.C. 7:27-22.27 below further describes the proposed provisions for alternative operating scenarios.

Phase-in of Initial Operating Permit Applications

The submittal of operating permit applications is proposed to be phased in over a 36 month period. Under the proposal, all of the initial operating permits (those for facilities in operation as of July 1, 1994) will be issued by November 15, 1999. The Department estimates that about 900 major facilities will require initial operating permits. The proposed phasing in will minimize the workforce needed for initial permit issuance.

The Department will continue to issue preconstruction permits and operating certificates for each major facility until the facility's initial operating permit is approved. (Note that, even though operating certificates must be maintained until the operating permit is issued, fees must be paid under the operating permit program, rather than the operating certificate program, as of July 1, 1994.) This approach will allow uninterrupted Department action on modifications to equipment at operating permit facilities.

In many cases, a facility will undergo some changes subject to preconstruction approval during the 18 months between the submittal of an application for an operating permit and the approval of the operating permit. Those preconstruction permit approvals will be incorporated into the operating permit by appending a list of the approved preconstruction permits to the draft and final operating permits. Preconstruction approvals, which have been subject to public comment, issued between the draft and final operating permits will be incorporated into the operating permit during the first five year renewal process.

Permit Revisions

The Department has proposed to incorporate into its operating permit program all of the permit revision processes included in the Federal rule. This maximizes operating flexibility and provides the appropriate level of information, review and comment for different kinds of permit revisions, considering the magnitude of potential changes to a facility. This proposal intends to clearly define what revisions are applicable for specific kinds of equipment or operational changes.

Kinds of proposed permit revisions include: administrative amendments; seven-day-notices; minor modifications; and significant modifications. These are listed in increasing order of environmental consequence, informational requirements, level of EPA oversight, and public participation.

Most of these kinds of permit procedures are analogous to procedures already utilized in the preconstruction permit program. The administrative amendment process is similar to the current amendment process; however, to conform with the Federal operating permit requirements, notice must now be contemporaneous with the informational change, rather than within 120 days. The minor modification process for operating permits is similar to the alteration process for preconstruction permits, except a 45 day EPA oversight period is included to be consistent with the Federal rules. The significant modification process for operating permits is similar to the process for a Prevention of Significant Deterioration permit, 40 CFR 51, which would be triggered by similar major increases in emissions. Minor facilities, not subject to operating permit requirements, will remain subject to the existing preconstruction permit.

The most significant new permitting process, introduced by the Federal operating permit rules and incorporated into this proposal, is the seven day notice change previously discussed under operating flexibility. This new procedure is proposed for both preconstruction permits and operating permits. This has been proposed consistent with EPA requirements for operating permits to achieve consistency between the preconstruction permit review process and the operating permit review process. The Department believes that both the earlier notifications (in the case of the seven day notices which were formerly amendments) and the deletion of preconstruction approval (in the case of seven day notices which were formerly alterations) are appropriate changes to the existing permit process. In particular, the allowance of a seven day notice for many changes which do not increase emissions, would provide substantial streamlining of the current permit revision process.

Permit Shield

EPA's Part 70 rules allow the State to incorporate a "permit shield" and an "application shield" in their operating permit rules. The Department has elected to incorporate both of these shields into this proposal.

The application shield protects the facility from penalties for operating without an approved operating permit if the facility has submitted a timely and administratively complete permit application. This applies to the initial operating permit and the renewal application for the facility. This shield stays in effect even if the Department does not complete its review of the application in a timely manner. The application shield is further explained in the summary of N.J.A.C. 7:27-22.7.

The permit shield provides protection from certain types of enforcement action after the operating permit is approved, so long as the facility is in compliance with the operating permit. This form of protection is based upon the premise that the operating permit should accurately reflect the air pollution control requirements applicable to the facility. Therefore, if the permittee operates the equipment and control apparatus in accordance with the operating permit, the permittee is presumed to be in compliance with the rules specifically identified in the permit and will be shielded from alternative interpretations of the rules. The permit shield is further explained in the summary of N.J.A.C. 7:27-22.17 below.

Fees

The CAA requires that the operating permit program must be supported by fees. Other sources of funding are prohibited. The CAA establishes a presumption that, in order to implement an adequate operating permit program, a state will have to charge a fee which, in the aggregate, equals or exceeds $25.00 per ton of air contaminants emitted per year in the State. Any State which charges less than this must provide a detailed analysis of its program and its financial needs, in order to obtain authorization from EPA for the lesser fee.

To satisfy this fee requirement, the Department is proposing to modify the existing fee schedule for preconstruction permits and operating certificates and to introduce new operating permit fees. The fee schedules being proposed will be sufficient to fund the operating permit program for at least Fiscal Year 1995 and Fiscal Year 1996. These fees are limited to the EPA presumptive minimum requirement of $25.00 per ton. The Department has completed two detailed reports, Workload Analysis and Fee Determination, which calculate the required fees. These reports are available from the Department at the address listed in the summary of N.J.A.C. 7:27-22.31, Fees, below.

Within this proposal, two alternative options for operating permit program fees are included. Currently, the APCA at N.J.S.A. 26:2C-9.2 authorizes the Department to charge up to $500.00 per service. However, this per-service fee structure is unnecessarily complex and makes it difficult to verify that the fees meet EPA's requirements. Therefore, the Department will ask the Legislature to amend the APCA to authorize the Department to charge a total annual fee based on a facility's total emissions, rather than a fee per individual service. In anticipation that the APCA may be amended, the Department is proposing two alternative annual fees: one based on the number of pieces of equipment at a facility (equipment fee), which is consistent with existing legislative authority; the other based on annual actual emissions (emissions fee), which is consistent with the Federal CAA fee system. Comments are encouraged on both fee calculation methods. See the summary of N.J.A.C. 7:27-22.31 below for a more detailed discussion of the fee requirements in the proposed new rule.

Subchapter 22 Summary

Currently, a facility's obligations under the CAA (ranging from emissions limits to monitoring, recordkeeping, and reporting requirements) are scattered among the provisions of the State Implementation Plan (SIP), which includes numerous Federally approved State rules and documents, and Federal regulations. Further, these requirements are currently incorporated into separate "operating certificates," applicable to each piece of equipment at a facility, often resulting in hundreds of separate certificates for each facility. This system can cause confusion over what requirements apply to a major facility at any given time, thus hampering the ability of the regulated public to comply with the requirements, as well as the ability of the Department to enforce them. The new rules and amendments provide a regulatory framework through

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which the Department will consolidate in a single document all air pollution control requirements which apply to a major facility.

Subchapter 22 does not impose any new air pollution control limitations. Rather, it provides a regulatory framework for consolidating and coherently implementing substantive State and Federal requirements. Among these are all existing requirements, as well as new Federal air toxics requirements and the new Federal acid deposition control (acid rain) program, which were added to the CAA through the 1990 amendments. Consistent with Part 70, the new operating permit program does add some procedural requirements such as monitoring, recordkeeping, and reporting, which are designed to aid in implementing the substantive requirements contained in other rules.

Subchapter 22 would be applicable to four general categories of facilities: (1) those facilities which emit, or have the potential to emit, significant amounts of hazardous air pollutants (HAPs), volatile organic compounds (VOC), nitrogen oxides (NO_x), or other air contaminants; (2) facilities subject to certain Federal standards, including those for HAPs or acid rain; (3) large municipal waste combustors; and (4) facilities that voluntarily elect to obtain an operating permit. The fourth category was added in response to suggestions to the Department at the October 1991 public workshop on the 1990 CAA Amendments. For a detailed discussion of the applicability of subchapter 22, see the summary of N.J.A.C. 7:27-22.2, Applicability, below.

EPA must review and approve each State's proposed operating permit program. This is done through a comprehensive submittal by the Department to EPA, including a description and explanation of the operating permit program, its legal authority, the adopted State operating permit rules, and associated documentation. This submittal is due to EPA by November 15, 1993. Part 70 allows States which substantially comply with the EPA operating permit program requirements to seek interim approval, which extends the time for the issuance of initial operating permits for two years. During the interim period, the State has an opportunity to refine the program, including refinements necessary to fully comply with any deficiencies identified by EPA. New Jersey will seek such interim approval, for which EPA's decision is due by November 15, 1994.

Upon approval of the State operating permit program, EPA must then oversee the State's implementation of the approved program. EPA will have 45 days to review and comment on all proposed operating permits, prior to the Department's issuance of the permit. The Department must address any EPA objections to the proposed operating permit to final issuance. Also, if EPA determines that the Department is not properly enforcing the operating permit requirements, EPA may itself take action against a violator. If EPA determines that the Department is following a pattern of failure to properly implement the program, EPA may rescind its approval of the program and administer the program itself.

A detailed description of the provisions of the proposed new rules follows:

N.J.A.C. 7:27-22.1 Definitions

N.J.A.C. 7:27-22.1 defines terms used in subchapter 22.

The following terms defined in subchapter 22 have the same definitions currently used elsewhere in N.J.A.C. 7:27: "actual emissions," "air contaminant," "air quality simulation model," "alteration," "applicable VOC," "attainment area," "BACT," "CFR," "carbon monoxide," "commercial fuel," "consumer price index (CPI)," "control apparatus," "criteria pollutant," "equipment," "federally enforceable," "lowest achievable emission rate," "lead," "major facility," "manufacturing process," "national ambient air quality standards," "NESHAPS," "New Jersey ambient air quality standard or NJAAQS," "nonattainment area" "NSPS," "operating certificate," "order," "oxides of nitrogen or NO_x," "person," "PM-10," "preconstruction permit," "PSD," "rate of production," "risk assessment," "source emission testing," "source operation," "stack or chimney," "state implementation plan (SIP)," "sulfur dioxide," "total suspended particulate matter," "TXS," and "use."

The following terms in subchapter 22 are defined consistently with definitions currently used elsewhere in N.J.A.C. and have recently been adopted in subchapter 8. The terms "co-product," "facility-wide permit," "intermediate product," "nonproduct output (NPO)," "pollution prevention assessment," "pollution prevention plan," "product," and "production process" are all consistent with the definitions of these terms at N.J.A.C. 7:1K-1.5.

As mentioned above, the operating permit program is intended to compile all existing substantive air pollution control requirements in a single operating permit. These requirements are defined as "applicable requirements" in Part 70. The proposed definition of "applicable Federal requirement" corresponds with the EPA definition of "applicable requirement," and includes: any standard or requirement provided for in New Jersey's approved State Implementation Plan (SIP); any condition of any preconstruction permit issued pursuant to N.J.A.C. 7:27-8; any Federal New Source Performance Standard (NSPS); any standard or other requirement under 42 U.S.C. 7412 (Hazardous Air Pollutants); any requirement concerning accident prevention under 42 U.S.C. 7412(r)(7) (implemented in New Jersey through the Toxic Catastrophe Prevention Act and Discharge Prevention; Containment and Countermeasures rules); any standard or requirement of the acid rain program under Title IV of the CAA; any requirement established pursuant to 42 U.S.C. 7761c(b), Operating Permit Requirements and Conditions, or 42 U.S.C. 7414(a)(3), Recordkeeping, Inspections, Monitoring and Entry (enhanced monitoring); any air pollution control standard governing solid waste incineration, consumer products, or tank vessels; any standard or requirement to prevent or control the emission of air contaminants from outer continental shelf sources; any standard or other requirement of the regulations promulgated to protect stratospheric ozone under Title VI of the CAA; any NAAQS; and any increment or visibility requirement for temporary sources permitted under the operating permit program.

Because New Jersey also plans to incorporate requirements stemming from State law, subchapter 22 also includes a proposed definition of "applicable State requirement." This term includes any air pollution control requirement, other than an applicable Federal requirement, which applies to a facility which is subject to this subchapter. This term includes requirements that have been promulgated by the Department and submitted to EPA as SIP revisions but not yet approved by EPA. The term "applicable requirement" is then defined in the rule to include both applicable State requirements and applicable Federal requirements. As required by Part 70, any applicable State requirements would be identified in the operating permit as such.

The proposed definitions of "affected state," "Affected Title IV facility" (this is referred to as an "affected source" in Part 70), "Affected Title IV unit" (this is referred to as an "affected unit" in Part 70), "draft operating permit" (this is referred to as "draft permit" in Part 70), "fugitive emissions," "general operating permit" (this is referred to as "general permit" in Part 70), "potential to emit" (discussed below in the summary of N.J.A.C. 7:27-22.2, Applicability), "proposed operating permit" (this is referred to as a "proposed permit" in Part 70), "renewal," and "responsible official" are consistant with the definitions of these terms set forth at 40 CFR 70.

The proposed definitions of "administrative amendment," "alternative operating scenario," "compliance plan," "compliance schedule," "emergency," "minor modification," "significant modification," and "temporary facility" are consistent with the use of these terms in Part 70, although they are not explicitly defined in Part 70.

The proposed definitions of "area source," "Hazardous Air Pollutant (HAP)," "GACT standard," and "MACT standard" are consistent with the definition of these terms at 42 U.S.C. 7412 Hazardous Air Pollutants. The term "major HAP facility" is introduced in order to distinguish between major sources as defined in Title III of the Clean Air Act Amendments (CAAA) of 1990 and other uses of the term major source found elsewhere in the CAA. The terms "construction of major HAP facility," and "modification of a major HAP facility" as used in N.J.A.C. 7:27-22.26 are an interpretation of meaning of these terms as they are used in the CAA Section 112(g). The definition of the term "reconstruction of a major HAP facility" follows the usage of the term reconstruction in the NSPS program. The Department anticipates that these proposed definitions of construction, reconstruction and modification for major HAP facilities will be consistent with the Section 112(g) modification regulations when they are adopted by EPA.

The proposed definition of "designated Title IV representative" is consistent with the definition of the term "designated representative" in Title IV of the CAA, which sets forth the acid rain program. The proposed definitions of "Phase I" and "Phase II" are also consistent with the use of these terms in Title IV of the CAA.

The proposed definitions of "Class I Substance" and "Class II Substance" are consistent with the definitions in Title VI of the CAA, Stratospheric Ozone Protection.

The new definitions used in subchapter 22 are described below, in the discussion of the substantive rule provision which uses the proposed defined term. They are: "accountable," "administratively complete application," "allowance," "application shield," "applicable state requirement," "chemical abstract service number," "Clean Air Act (CAA),"

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"continuous data recorder," "continuous emission monitor," "continuous monitoring system," "continuous opacity monitor," "continuous process monitor," "de minimis," "development," "DOT," "emissions," "emissions cap," "enforceable," "exempt activity," "existing facility," "facility," "Federal implementation plan," "final operating permit," "initial operating permit," "insignificant source operation," "install," "intra-facility emission trading," "major hazardous air pollutant facility," "manufacturing process," "maximum allowable emissions," "monitoring," "operating permit," "permittee," "quantifiable," "replace," "replicable procedure," "research," "seven-day-notice change," "shut down," "SIC code," "significant source operation," "substantial component," "USC" and "volatile organic compounds."

N.J.A.C. 7:27-22.2 Applicability

This section establishes which facilities will be subject to subchapter 22 and thus will need operating permits. Subchapter 22 covers all those facilities required to be included by EPA's operating permit rule, 40 CFR 70, as well as a small number of other facilities. A "facility" is defined in the proposed rule as including all structures, buildings and installations located on property controlled by the same person. This definition is consistent with the CAA definition of "source."

N.J.A.C. 7:27-22.2(a) sets forth the types of facilities which are subject to subchapter 22. These facilities primarily emit air contaminants in major amounts as set forth in the EPA Part 70 rule. Such facilities are commonly referred to as "major facilities" or "major sources." One of the main criteria which would determine whether a facility requires an operating permit is its potential to emit. "Potential to emit" is defined in the proposed rule as a facility's maximum ability to emit air contaminants under its physical limitations and legal restrictions. The Department's definition of potential to emit is consistent with that in Part 70, except that the Department explicitly includes all "fugitive emissions" in its determination of all facility's potential to emit, whereas EPA guidance excludes fugitive emissions when calculating the potential to emit for certain facilities. "Fugitive emissions" are emissions which escape into the atmosphere independently of a stack, chimney or other discharge device. EPA requires "fugitive emissions" to be included in the calculation of a facility's "potential to emit" for 27 named source categories or for any facility regulated by Title I of the CAA. This rule proposal elects to include fugitive emissions for all source categories.

It is important to include fugitive emission in the applicability determinations for requiring operating permits in order to ensure that the environmental benefits of an operating permit are achieved from all major sources of air contaminants emissions. As discussed in the Environmental and Social Impact statements of this proposal, an operating permit clarifies air pollution control requirements for major emitting facilities, resulting in better compliance, lower emissions, air quality improvement, and health and welfare benefits. The applicability of an operating permit and the realization of these benefits should logically be the result of total potential emissions, whether they be from a stack or fugitive.

Including fugitive emissions in applicability determinations is also equitable from a competitiveness standpoint. Under the Federal rule, at 40 CFR 70.3(d), once a facility is subject to an operating permit for whatever reason, all fugitive emissions must be included in the application and permit. However, Part 70 might be interpreted to allow a large fugitive emission source to be exempt from obtaining an operating permit if there are no major stack emissions at a site. It is not fair from an economic standpoint to exempt a very large fugitive emission facility from an operating permit, while requiring an operating permit from a moderate size facility to include a smaller amount of the same or smaller type of fugitive emissions within the application and permit. For example, a quarry emitting 300 tons per year of fugitive particulate emissions must not need an operating permit under the Federal rule if there were no other major stack emissions on the site. However, an asphalt plant which emits 30 tons of nitrogen oxide per year must include its fugitive particulate emissions, even if they are only 10 tons per year. Also, if the asphalt plant was located at a small quarry emitting another 20 tons per year of fugitive particulate emission, this too must be included in the operating permit. Hence, the Federal applicability criteria for fugitive emissions would result in inequities between facilities which emit fugitive emissions, even to the extent of requiring more of a smaller source of fugitive emissions than a larger source. The Department's proposal would eliminate this inequity and result in all sources of fugitive emissions being treated the same for permit applicability, as well as permit content.

As in the example above, the type of source that might be exempt from operating permits if fugitive emissions are not included in calculating potential to emit for unlisted sources in attainment areas, are sources that not only emit large quantities of particulate matter as fugitive emissions and would not otherwise be subject to the operating permit requirements considering particulate stack emissions. In New Jersey, the only facilities meeting these criteria are likely to be certain large quarries. If such a facility were located in an area which is in attainment for particulates, and the facility did not emit any other contaminant in significant amounts, the Federal omission of fugitive emissions from the facility's potential to emit might result in a determination that no operating permit is needed for the facility.

For the reasons described above, the Department believes that the inclusion of fugitive emissions in the assessment of a facility's potential to emit will not cause a significant number of additional facilities, not subject to operating permit requirements under Part 70, to become subject to the New Jersey operating permit program, and further, that the inclusion of any such facilities in the operating permit is appropriate.

An operating permit must be obtained for any facility which has the potential to emit certain defined levels of air contaminants. An "air contaminant," as defined at N.J.A.C. 7:27-22.1, is any substance, other than water or distillates of air, present in the atmosphere as solid particles, liquid particles, vapors or gases. This definition encompasses the term "regulated air pollutant," which is defined in Part 70.

The definition of "air contaminant" includes volatile organic compounds or "VOC." VOC is proposed to be identical to the Federal definition of this term set forth at 40 CFR 51.100(s). The Department has also recently proposed to change the definition of VOC currently used by the Department in N.J.A.C. 7:27-16 to mirror the Federal definition (see 25 N.J.R. 3339(a)). Permit data must be reported in a manner consistent with EPA's definition of VOC to be integrated onto the Federal database. For these reasons, the definition of VOC proposed herein is identical to the Federal definition of that term.

Facilities are also subject to subchapter 22 if they emit significant levels of hazardous air pollutants. Such facilities are referred to as "major HAP facilities." The proposed definition of "hazardous air pollutant" or "HAP" is consistent with the definition of this term in 42 U.S.C. §7412.

Even though Part 70 allows minor NSPS sources to be deferred, the Department proposes to include such sources, because New Jersey is a densely populated state with large segments of citizens living in close proximity to industrial areas. Consequently, the Department has taken a proactive role in regulating hazardous air pollutants. The Department estimates that this inclusion of minor NESHAP sources will affect approximately 21 facilities that are not major and would not otherwise be affected by these rules. This ensures that all facilities subject to NESHAPS, except those exempted (that is, wood stoves, asbestos removal), will be covered by an operating permit. The Department has not included other minor sources of other air contaminants consistent with EPA's deferral of minor sources.

Other facilities specified by the Federal Part 70 rule as requiring operating permits are also listed in N.J.A.C. 7:27-22.2(a). These include any facilities subject to the acid rain requirements set forth at Title IV referred to as an "affected Title IV facility" and combustors or more than 250 tons of municipal waste per day.

N.J.A.C. 7:27-22.2(b) sets forth facilities which are exempt from subchapter 22, consistent with Part 70. These are facilities only subject to the standards for residential wood heaters or the emission standards for asbestos demolition. EPA has exempted these sources.

N.J.A.C. 7:27-22.2(c) would allow research and development (R&D) equipment to be treated as a separate facility for the purpose of determining the applicability of this rule. This is consistent with EPA's Part 70 operating permit rule which allows R&D equipment separation for facilities that have both R&D operations and manufacturing operations. Under this approach, all the R&D equipment would be treated as though it were a separate facility, and this R&D equipment would need an operating permit only if its potential emissions would be a major source. However, research and development operations may not be treated as a separate facility for the purposes of modeling or risk assessment.

N.J.A.C. 7:27-22.2(d) provides that an owner or operator of a facility subject to the Department's operating certificate requirements at N.J.A.C. 7:27-8 may elect to obtain an operating permit to replace the operating certificates for each source operation in the facility. This provides a permittee with a comprehensive permit covering an entire

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facility, which may be easier to follow than multiple operating certificates. The operating permit process also enhances accountability by introducing public comment on more permits.

N.J.A.C. 7:27-22.3 General provisions

N.J.A.C. 7:27-22.3 establishes the general requirements and several specific elements of the operating permit program. Details, concerning the implementation of these requirements, follow in subsequent sections.

N.J.A.C. 7:27-22.3(a) through (f) specify the basic responsibilities of an owner or operator of a facility subject to the proposed operating permit requirements. N.J.A.C. 7:27-22.3(b) specifies that the owner or operator of a facility subject to an operating permit may not operate any equipment, control apparatus, or source operation without a valid operating permit.

According to N.J.A.C. 7:27-22.3(c), no equipment or control apparatus may emit air contaminants other than those allowed by a valid operating permit, except those contaminants emitted at lower than de minimis levels. A discussion of the de minimis threshold levels can be found at the summary of N.J.A.C. 7:27-22.6 below. Emissions of air contaminants in amounts greater than that allowed by the operating permit are also prohibited.

N.J.A.C. 7:27-22.3(d) and (e) specify that the owner or operator of a facility covered by an operating permit must maintain and operate equipment and control apparatus in good condition and must operate in compliance with the operating permit requirements. The Department especially encourages comment on the appropriate level of detail which should be included in operating permits, and the types of operating specifications which should be referenced in the permits.

N.J.A.C. 7:27-22.3(f) specifies that, for facilities with more than one owner or operator, each owner or operator is jointly and severally liable for any fees or penalties for violations of subchapter 22.

N.J.A.C. 7:27-22.3(h) provides that, once the deadline for a facility to submit an operating permit application has passed, the facility is subject to all of the requirements in this subchapter. However, the Department offers an "application shield" which allows a facility to operate while the Department is reviewing the application, if the facility has submitted an application that is both "timely" and "administratively complete." Under the application shield, if the facility's application was both timely and complete, the facility will be shielded from penalties for operating without a permit during the time the application is being reviewed. The facility must continue to comply with all other applicable requirements during this period. Further details on the application shield are discussed in the summary of N.J.A.C. 7:27-22.7, Application shield, below.

In conformance with 40 CFR 70.4(b)(3)(iii), N.J.A.C. 7:27-22.3(i) establishes the term of an operating permit as no greater than five years. Part 70 at 40 CFR 70.6(a)(2) allows the Department to issue permits for certain municipal solid waste incineration units for a term of up to 12 years if the Department reviews such permits at least every five years. However, the New Jersey Air Pollution Control Act (APCA), at N.J.S.A. 26:2C-9, does not allow for any permit term longer than five years, nor does the Department believe that a longer term than five years is necessary or appropriate. Therefore, the Department is proposing to issue operating permits for solid waste incineration units combusting municipal waste for the same five year term as all other operating permits.

Consistent with 40 CFR 70.6(b), N.J.A.C. 7:27-22.3(j) specifies that when the operating permit expires, so does the permittee's right to operate the facility. However, as set forth in N.J.A.C. 7:27-22.3(h), a permittee may continue to operate the facility pursuant to an application shield if the renewal application was timely and complete. This would allow the facility to operate while the Department is reviewing the application.

Pursuant to N.J.A.C. 7:27-22.3(k), the Department may issue a single operating permit for a temporary facility which will be operated in more than one location during the term of the operating permit. Detailed provisions for temporary facility operating permits are found in N.J.A.C. 7:27-22.15.

N.J.A.C. 7:27-22.3(l) implements the requirement at 40 CFR 70.6(a)(9) that, if requested, the State must issue operating permits which include alternative operating scenarios. If approved, an alternative operating scenario allows a facility to change from one type of production or process to another, without applying to the Department for approval of a modification to the operating permit. Detailed provisions for alternative operating scenarios are found in the proposed new rule at N.J.A.C. 7:27-22.27. This section also authorizes facilities with an approved intra-facility emissions trading program to make changes without revising their operating permit. Detailed intra-facility emissions trading provisions are proposed at N.J.A.C. 7:27-22.28.

N.J.A.C. 7:27-22.3(m) implements 40 CFR 70.6(a)(1)(iii) which allows the Department to determine and apply an alternative to an emission limit, equivalent to or more stringent than an emission limit contained in an applicable requirement. Proposed N.J.A.C. 7:27-22.3(m) also requires that any such alternative emission limit must be quantifiable, accountable, enforceable, and based on replicable procedures. Such alternative limits are useful where the measurement of something other than emissions provides a more economical or more easily enforceable means of determining emissions. For example, if direct emissions of sulfur dioxide are difficult or very expensive to measure, compliance with sulfur dioxide emission limits could be accurately determined through measuring the amount of sulfur in certain by-products from the facility. A limit on the sulfur in these by-products could then be included in the operating permit as an alternative to a limit on sulfur dioxide emissions, resulting in equivalent emission reductions without unnecessary expense to the facility. Although the Department is not required to provide this alternative, it is included in the proposed rule to increase flexibility for regulated facilities.

N.J.A.C. 7:27-22.3(n) states that operating permits do not convey property rights of any sort, nor any exclusive privilege. This provision clarifies the exact nature of the operating permit as a license, rather than a property interest.

N.J.A.C. 7:27-22.3(o) sets forth the requirement that any transfer of ownership or operational control which would change the name of identity of the permittee for the facility, requires a transfer of the operating permit. This transfer may be accomplished as an administrative amendment to the operating permit.

N.J.A.C. 7:27-22.3(p) requires a preconstruction permit pursuant to N.J.A.C. 7:27-8 for any change which constitutes a minor modification or a significant modification, made at a facility subject to operating permit requirements.

The proposed provisions at N.J.A.C. 7:27-22.3(q), (r) and (s) are general requirements regarding certification of information submitted to the Department. All information submitted will be treated as public information unless a confidentiality claim for the information is made and upheld. Also note that submittals to the Department do not stay permit conditions, rules, or other legal obligations.

The address to contact to obtain application forms, instructions, and information regarding this subchapter is provided at N.J.A.C. 7:27-22.3(t).

N.J.A.C. 7:27-22.3(u) states that if an additional applicable requirement becomes applicable to the facility, or an applicable requirement which was previously applicable to the facility changes, a permittee must incorporate the change or addition into the operating permit.

Upon request of a permittee, the Department may terminate the operating permit, pursuant to N.J.A.C. 7:27-22.3(v). This allows a permit to be terminated in the event of a facility shutting down. The permittee may not, however, unilaterally terminate the operating permit, as long as any equipment subject to operating permit requirements continues to operate at the facility.

According to N.J.A.C. 7:27-22.3(w) except as provided in an express permit shield, an operating permit does not relieve a person from the obligation to comply with all applicable laws, rules or regulations relating to the facility.

N.J.A.C. 7:27-22.3(x) provides that, if there is any conflict between the requirements of N.J.A.C. 7:27-22.29, which pertains to acid deposition control, and any other requirement of this chapter, the requirements of N.J.A.C. 7:22-29 shall prevail for any affected Title IV facility.

N.J.A.C. 7:27-22.3(y) explains that facilities that need an operating permit must maintain their operating certificates pursuant to N.J.A.C. 7:27-8, until the operating permit is issued.

N.J.A.C. 7:27-22.3(z) explains that subchapter 22 shall become operative on July 1, 1994. This operative date will provide ample opportunity for the regulated public to prepare to meet all requirements of the proposed rules.

N.J.A.C. 7:27-22.4 General application procedures

The proposed provisions at N.J.A.C. 7:27-22.4(a), (b), (c) and (d) establish the general procedural requirements for all operating permit applications submitted to the Department. The Department has received valuable input in the development of application forms from three ad

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hoc groups known as the Industrial Advisory Group (IAG), the IAG Operating Permit Workgroup and a Utilities Workgroup. The application must be submitted on standard application forms, and must include all information and attachments required by the instructions accompanying the application form. An applicant may, upon receiving written approval from the Department, submit an application electronically. The Department will establish standards and protocols through issuance of a manual which should be available after January 1994, at the same address as the application forms specified in this section. It has sought, and will continue to seek, public input into the development of these forms and this manual.

Proposed N.J.A.C. 7:27-22.4(e) advises applicants to submit an application at least 90 days prior to the application deadline for the facility. This option is provided to applicants because, in order to be eligible for an application shield, an application must be both timely and administratively complete. Because applications for initial operating permits, renewals, and significant modifications are very complex, the submittal of an application at least 90 days prior to the applicable deadline provides the applicant and the Department sufficient time to correct deficiencies in the application before the deadline for an administratively complete application. For those who submit early applications pursuant to this subsection, the Department will issue a letter to the applicant, within 30 days after receipt of the early application, which indicates how, or if, the application is insufficient.

N.J.A.C. 7:27-22.5 Application procedures for initial operating permit

The proposed rule, at N.J.A.C. 7:27-22.5(a), specifies the procedures to be used when applying for an initial operating permit. An "initial operating permit" is the first operating permit issued to a facility pursuant to this subchapter. Application procedures and deadlines for changes to existing operating permits accomplished through administrative amendments, seven-day notices, and significant and minor permit modifications are included in the sections dealing with those changes.

N.J.A.C. 7:27-22.5(b) establishes the requirement that a timely and administratively complete application for an initial operating permit be submitted to the Department within the specified deadline established in this subchapter. If an owner or operator fails to submit an application by the deadline, it is subject to penalties, pursuant to N.J.A.C. 7:27A.

Facilities which are already in operation prior to the effective date of subchapter 22 are required to submit complete operating permit applications in accordance with the schedule outlined in N.J.A.C. 7:27-22.5(c). The schedule separates facilities by industry type using Standard Industrial Classification (SIC) codes, and requires different deadlines for different groups of industries. There are also some facilities classified according to other criteria, such as their inclusion in the acid rain program, or their designation by EPA as a class of facilities requiring an operating permit.

The phasing in of applications according to industry type was included in the rule so that applications for facilities in similar industries will all be reviewed simultaneously and to distribute the review of operating permit applications in the time allowed. With the phase in of applications by industry type, applications from competitors within the same industry will be reviewed at the same time. This approach will also allow the Department to streamline its permit review activities by focusing resources on similar applications. This approach also will help ensure that different facilities within an industry are handled consistently, thereby minimizing the possibility of inconsistencies creating competitive advantages or disadvantages. Finally, the phase in will enable the Department efficiently to develop the staff and resources to handle this major new program over a period of years. This approach is consistent with the Part 70 criteria for States like New Jersey seeking interim operating permit program approval, set forth at 40 CFR 70.4.

In developing the specific proposed schedule by which different industries are required to submit applications, the Department targeted large emitters and industries with which the Department has longstanding experience for early applications. In keeping with this strategy, many of the most complex facilities (which generally are not the large emitters) will submit applications during the last phases of permitting thus providing the Department with the opportunity to better focus on the difficult technical issues raised by those types of facilities.

Proposed N.J.A.C. 7:27-22.5(d) provides that a facility may be required to obtain an operating permit prior to the deadlines in this section, as a result of the EPA promulgation of MACT or GACT standards for HAPs. The specific proposed provisions relating to MACT and GACT standards are set forth at N.J.A.C. 7:27-22.26. Should a MACT or GACT standard be promulgated by EPA prior to a facilities application deadline, the Department will issue an operating permit which covers only the equipment subject to the MACT or GACT standard, not the entire facility.

The proposed rule provides at N.J.A.C. 7:27-22.5(e) that facilities whose only applicable requirement is a MACT or GACT standard, and which emit less than 10 tons per year of a single HAP or 25 tons per year of all HAPs, are not required to apply for an operating permit for the entire facility. If, however, there are other factors which subject the facility to the operating permits rule, the owner or operator of the facility must apply for the initial operating permit only for the equipment or control that is subject to the MACT or GACT standard, and then apply for a modification of the operating permit to include the entire facility prior to the application deadline for the facility.

For facilities that have not yet commenced operation as of the application deadlines indicated in the proposed rule, N.J.A.C. 7:27-22.5(f) provides that applications must be submitted to the Department no later than 12 months after the date that the Department issues a preconstruction permit for the facility. This provision is consistent with 40 CFR 70.5(a)(1)(i). Facilities subject to operating permit requirements that commence operation after November 15, 1999 must obtain an approved operating permit prior to commencement of operating the equipment at the facility. The initial application approval process takes 18 months; therefore, the applicant must submit the application at least 18 months prior to the planned commencement of operation.

Pursuant to N.J.A.C. 7:27-22.5(g), facilities which become subject to subchapter 22 through a change that would be a minor modification if an operating permit had been issued for the facility are required to submit operating permit applications within 12 months after the altered source operation begins operating. However, for any such change which would be a significant modification if an operating permit had been issued for the facility, the operating permit must be approved before the changed operation commences operation.

Pursuant to proposed N.J.A.C. 7:27-22.5(h), facilities which become subject to subchapter 22 through a change to any applicable requirement, other than a MACT or GACT standard, must submit an application for an operating permit within 12 months after the effective date of the new requirement, unless the requirement itself mandates a different date for the application.

An owner or operator at a facility with over 100 stacks or chimneys may elect to divide the facility into two or more components and submit separate initial operating permit applications for each component. N.J.A.C. 7:27-22.5(i) presents the details for this type of application submittal.

The proposed rule at N.J.A.C. 7:27-22.5(j) requires that an owner or operator provide a copy of the administratively complete application for an initial operating permit to the EPA and any affected state within 30 days of the Department's completeness determination.

N.J.A.C. 7:27-22.6 Application contents

An application for an initial operating permit must include specific information concerning the compliance status; source operations; allowable emission levels; other applicable requirements; and relevant testing, monitoring and recordkeeping to ensure compliance. If an applicant wishes to take advantage of certain flexibility provisions described in other sections of the rules, additional information must be submitted on the application. The application must be certified by a responsible official. The unique features of both the mandatory requirements and optional provisions of an application for an operating permit will be discussed in this section.

Source Operation: "Source operation" means any process, or any identifiable part thereof, that emits or can reasonably be anticipated to emit any air contaminant either directly or indirectly into the outdoor atmosphere. A source operation may include one or more pieces of equipment or control apparatus. This term includes the term "emissions unit" as defined at 40 CFR 70.2. Because the definition of source operation is very broad and may include sources that are trivial, the Department is proposing that "source operation" be broken down into three categories of source operations: exempt activities, insignificant source operations and significant source operations. Exempt activities, such as laundry operations or janitorial activities, are listed at N.J.A.C. 7:27-22.6(c), and need not be included in the operating permit application. Both insignificant and significant source operations must be

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included in this application. While insignificant sources need only be listed in the application, a higher degree of detail is required for significant source operations.

Insignificant Sources: Part 70 requires that, if a state exempts "insignificant sources" from review because of size, emission levels or production rate, they must be listed in the application. This list must contain enough information to identify the sources qualifying for such an exemption. This is important for both the facility and the Department as the list provides information for sources that do not need to be described in the application. The term used in subchapter 22 for these particular source operations is "insignificant sources."

Insignificant source operations must be listed in the application, along with an aggregate estimation of the total potential to emit from all of the insignificant source operations. It is the responsibility of the applicant to determine what source operations at its facility qualify as insignificant, pursuant to N.J.A.C. 7:27-22.6(e).

The Department has relied on subchapter 8 applicability levels to derive the insignificant source categories for the operating permit program. The source operations and equipment listed in N.J.A.C. 7:27-22.6(e)4 as insignificant are consistent with the exclusion criteria established in N.J.A.C. 7:27-8. Consequently, the source operation applicability levels for the operating permit will be consistent with the applicability levels for a preconstruction permit.

De Minimis Emissions: The Department realizes that there is no practical value in conducting an extensive review of emissions that are insignificant or de minimis. Therefore, de minimis emission levels are being proposed for hazardous air pollutants and other air pollutants. These de minimis emissions levels are relevant to the determination of insignificant sources and are described herein. The de minimis emission levels are also used to determine what air contaminants are specified for significant sources.

The Department has chosen to identify insignificant source operations in terms of specific source operations as well as de minimis emission rates. The source operations which are considered insignificant are listed in N.J.A.C. 7:27-22.6(e)4. In addition, these sources must not exceed the de minimis emission rates that are established for individual pollutants and some groups of pollutants regulated under the Operating Permit Program. The de minimis rates are listed in Tables A and B of the rule. Table A referred to in N.J.A.C. 7:27-22.6(e)2, Thresholds for De Minimis Emissions of Hazardous Air Pollutants, was developed as a fraction, generally 1/10 of the applicability levels being developed by EPA's Office of Air Quality Planning and Standards 112(g) workgroup for applying new source MACT standards to modified sources of HAPs. DEPE has actively participated as a member of this workgroup.

The de minimis emission levels for listing in the operating permit application have been chosen to be sufficiently low to provide data on sources below the trigger levels for the Department's substantive requirements. The de minimis levels provide sufficient emission information in a permit to provide the Department with a reasonable assurance that sources are below existing exclusion rates for requiring control devices and other "trigger levels" for applicable requirements. This also provides the Department with sufficient information on emissions from small sources to determine if the trigger levels for applicable requirements should be lowered. The Department believes that it set the reporting levels low enough to give the Department sufficient information to protect the environment but not so low as to require the reporting of inconsequential information. The Department is especially seeking comment on the appropriateness of these de minimis reporting requirements.

Table B referred to in N.J.A.C. 7:27-22.6(e)2, Thresholds for De Minimis Emissions of Other Air Pollutants, was established by reducing the minimum regulated particulate levels expressed in N.J.A.C. 7:27-6 by 10 fold. This was accomplished by reducing the exclusion rate in Table 4, Column 4, Range G, of N.J.A.C. 7:27-16.6(a) for VOC's by 10 fold and by setting the de minimis levels of NO_x, CO, SO_2 and any other air contaminants at the same 0.05 pounds per hour. The Department believes that this level is low enough to be insignificant for quality purposes and is uniformly consistent for the air contaminants which are not HAPs. Table B is also consistent with the de minimis concept and levels recommended by the De Minimis Workgroup which was formed as part of the Department's Clean Air Workgroup.

Significant Source Operations: Source operations that are neither exempt nor insignificant would be considered significant source operations and must be fully described in the operating permit application. Data relative to these source operations would constitute the major portion of the operating permit application and include those source activities normally associated with air contaminant emissions such as boilers, kilns, chemical processing equipment and other manufacturing equipment.

Draft Operating Permits: Along with an application for an initial operating permit, a renewal, a significant modification and a minor modification, the Department suggests that an applicant submit draft operating permit conditions. This will allow the applicant to submit provisions, which, if accepted by the Department, may be directly inserted into the operating permit, and thereby streamline the permitting process. For example, an applicant may recommend that its equipment is best suited for certain monitoring, testing and recordkeeping requirements. This "draft your own draft permit" concept has been used successfully in other of the Department's programs.

Application Requirements: The required contents for an application for an initial operating permit are set forth at N.J.A.C. 7:27-22.6(f). Among the application contents called for by this section, N.J.A.C. 7:27-22.6(f)6 would require that all relevant information pertaining to air pollution control requirements be supplied in the application. The application must also include all applicable requirements and their regulatory citation for each significant source operation at the facility and the facility as a whole.

Compliance Plan: As proposed at N.J.A.C. 7:27-22.6(f)8, all applications for an initial operating permit would include a proposed compliance plan which meets the requirements of N.J.A.C. 7:27-22.9. A compliance plan reports the compliance status of the facility. If the facility is out of compliance with any requirement, the compliance plan must include a compliance schedule which contains an enforceable sequence of actions, with milestones leading to compliance.

Risk Assessment: The Clean Air Act Amendments of 1990 require EPA to review the residual risk from major sources eight years after Maximum Achievable Control Technology standards are promulgated. If after controls are applied for a source category, the most exposed individual still has a cancer risk of one in a million or greater, then EPA must promulgate more stringent standards for that source category. The Department currently examines this residual risk (risk from emissions after controls are applied) for some HAPs, as part of the existing preconstruction permit program. This will continue, even though the Federal program will not begin for several more years.

The Department also proposes to include a partial risk assessment as part of the Operating Permit Program. The Department has initiated this substantive application requirement in advance of EPA's requirements in order to address public concerns over health effects of toxic air contaminant emissions and to begin to gather the information that will be needed to do the Title III risk assessments. A partial risk assessment would be conducted for any facility with annual emissions of HAPs in excess of those specified at N.J.A.C. 7:27-22.8. These trigger limits for risk assessment were developed to screen out sources with obviously negligible risk, with conservative assumption for stack height, distance to property line, and local meteorology. The requirements of the risk assessment are described in more detail below under N.J.A.C. 7:27-22.8, Air quality simulation modeling and risk assessment.

A risk assessment is a procedure for characterizing the probability that potential exposure to air contaminants will result in adverse effects on human health, welfare, or the environment. If the applicant must submit air quality simulation modeling or risk assessment pursuant to N.J.A.C. 7:27-22.8, then additional information is required by N.J.A.C. 7:27-22.6(f)10, to be submitted with the application. If modeling and risk assessment are not required, the application must include a statement which declares that all emissions are below the applicability levels for a risk assessment.

Replacement of Equipment: An applicant who seeks to include authorization for the replacement of equipment in its operating permit must request this in its application. Pursuant to N.J.A.C. 7:27-22.6(k), in order to process the change as a seven-day notice, the applicant must provide a schedule with expected dates of replacement. This proposed revision in N.J.A.C. 7:27-22.22 allows the applicant flexibility in replacing substantial components with equivalent or better components, provided the replacement is authorized in the operating permits. This provision would be limited to control apparatus which must be replaced on a normal schedule, such as certain catalysts, or to control apparatus for which replacement apparatus are on-site in case of a modification.

General: N.J.A.C. 7:27-22.6 sets forth the Department's minimum requirements for initial operating permit applications. All of the requirements of this section must be met in order for the Department to consider an application as "administratively complete." N.J.A.C.

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7:27-22.6(g), (h), (i) and (j) require additional information from an applicant who is proposing any alternative operating scenarios, any intra-facility emissions trading, any special conditions for startup or shutdown or necessary equipment maintenance, or anticipates making any seven-day notice changes.

General Operating Permits: Pursuant to N.J.A.C. 7:27-22.6(1), if an applicant desires to include general operating permit conditions as part of its operating permit, it must specify in its application the general operating permit for which it believes it qualifies. If the Department determines that a general operating permit is applicable to equipment of the facility, its generic conditions will be incorporated into the operating permit.

Non-Applicable Requirements: As provided in N.J.A.C. 7:27-22.6(m), the application may specify provisions or requirements which the applicant believes do not apply to its facility, and the Department may confirm such non-applicability in the operating permit. An applicant may wish to do this in order to eliminate any uncertainty as to the applicability of a provision in a rule. Also, the permit shield provides that compliance with the operating permit also constitutes compliance with all requirements specifically included in the operating permit, including any specific provisions which the permit specifically identifies as not applicable.

Early Reductions of HAP Emissions: Any applicant seeking a compliance extension for a MACT or GACT standard must demonstrate in the application that sufficient early reductions of HAPs emissions have been achieved, qualifying them for this program. The conditions for an early reduction extension of MACT or GACT may be found in proposed N.J.A.C. 7:27-22.26.

N.J.A.C. 7:27-22.7 Application shield

This section provides for an "application shield" for any applicant that submits a timely and administratively complete application for an initial operating permit or renewal. According to section 70.5(a)(2) of EPA's Part 70 rule, the facility's ability to operate without an operating permit shall be in effect from the date the application is determined or deemed to be complete until the final operating permit is issued, provided that the applicant submits any requested additional information by the deadline specified by the permitting authority. This "application shield" allows a facility to operate even though it is not covered by a valid operating permit, until the Department takes final action on the application. Without an application shield, the facility is subject to penalties for operating without an operating permit from the application deadline until the Department issues an operating permit. An application shield does not protect against enforcement action for other violations, such as noncompliance with emission limits or recordkeeping requirements. Application shields are required by Part 70.

N.J.A.C. 7:27-22.7(b) provides that an application shield can apply only if two conditions are met: (1) the application is submitted within the application deadline set forth in N.J.A.C. 7:27-22.4, General application procedures; and (2) the application is administratively complete by that deadline. According to N.J.A.C. 7:27-22.7(c), the protection afforded by the application shield begins on the date the application is due to the Department.

N.J.A.C. 7:27-22.7(d) specifies that, if either of the two conditions for an application shield is not met, the application is ineligible for the application shield. The Department expects that some applicants will not submit an application which meets the requirements for administrative completeness as this is a new program that has many complexities. Therefore, the Department has included a provision in the general application procedures section at N.J.A.C. 7:27-22.4 which encourages applicants to submit the application at least 90 days prior to the actual application deadline, so that the Department can issue an administrative completeness determination within 30 days. This would allow the applicant 60 days to correct any deficiencies before the application deadline.

Proposed N.J.A.C. 7:27-22.7(e) establishes that the application shield does not provide protection from enforcement action for noncompliance with the other requirements of this subchapter, permits, orders, or other legal documents.

Proposed N.J.A.C. 7:27-22.7(f) delineates the circumstances under which an application shield terminates. The shield terminates upon the Department's final action on the application, or upon the applicant's failure to submit information within the deadline set by and as required by the Department.

N.J.A.C. 7:27-22.8 Air quality simulation modeling and risk assessment

This section explains the conditions under which applicants must address the effect of facility air contaminant emissions on public health. The potential for adverse health effects can be evaluated by the use of air quality simulation modeling of facility emissions and an assessment of the risk posed by the predicted concentrations of certain hazardous air pollutants that have either carcinogenic or noncarcinogenic health effects. Air quality simulation modeling accounts for the dispersive capacity of the atmosphere and other relevant factors, to predict the concentration of an air contaminant in the ambient air. Models developed and/or approved by EPA will be used for this analysis.

N.J.A.C. 7:27-22.8(a) requires applicants for an initial operating permit to perform air quality simulation modeling and risk assessment for facilities that emit, or propose to emit, significant quantities of certain hazardous air pollutants. Risk assessment characterizes the probability that potential exposure to air contaminants will result in adverse effects on human health or welfare or the environment. While Title III of the CAA does not require these analyses until eight years after EPA adopts standards for the emission of hazardous air pollutants, the Department currently performs similar analyses when reviewing applications for preconstruction permits from facilities proposing to emit a limited number of toxic substances. The Department's proactive policy regarding risk assessment for hazardous air contaminants was developed because New Jersey has many communities located in close proximity to industrialized areas of the State. Consistent with this policy, the Department proposes to require risk assessment for facilities emitting or proposing to emit significant emission quantities of certain toxic substances. This requirement will substantially expand the Department's current knowledge of the risks posed by HAP emissions in New Jersey.

One of the workgroups that was formed in 1991, to get input from interested parties, addressed the issue of modeling and risk assessment in the Operating Permit program. This workgroup assisted the Department in streamlining the requirements of this section in order to focus the effort of the applicant and Department staff on the sources that have the greatest potential to have an impact on public health. Some of these streamlining techniques include: (1) requiring risk assessment for a limited number of pollutants in the application for initial operating permits; (2) setting thresholds for addressing those pollutants; and (3) the use of simplified procedures to screen out low risk facilities. The limited list of pollutants is described below.

To address the most likely potential public health risks, N.J.A.C. 7:27-22.8(a) proposes that a risk assessment be performed for emissions of the most hazardous HAP emissions in a facility's initial operating permit, while requiring a risk assessment for the less hazardous HAP emissions be done in their operating permit renewal. Thus, the rule requires that any facility whose potential to emit exceeds any of the following thresholds will be required to prepare and submit a risk assessment as part of their initial operating permit application:

1. For total dioxins and furans, 0.001 pounds per year;
2. For benzidine or bis (chloromethyl) ether, 0.6 pounds per year;
3. For n-nitrosodimethylamine, 2.0 pounds per year;
4. For hexavalent chromium compounds, 4.0 pounds per year;
5. For hydrazine, 8.0 pounds per year;
6. For arsenic and arsenic compounds, or for 2-nitropropane, 10.0 pounds per year.
7. For any hazardous air pollutant listed in Table A of N.J.A.C. 7:27-8, 20 pounds pe year; and/or
8. For any hazardous air pollutant listed in Table B of N.J.A.C. 7:27-8, 200 pounds per year.

The thresholds listed in Items 1 through 8 above were developed following the tentative draft rules used by EPA's Office of Air Quality Planning and Standards 112(g) workgroup to establish de minimis levels for purposes of allowing intra-facility trading for modified sources of HAPs. New Jersey DEPE has actively participated as a member of the workgroup which is developing this regulation. A set of de minimis levels for insignificant source operations was developed for use as described in N.J.A.C. 7:27-22.6, Application contents. The thresholds for modeling and risk assessment are set at a level that is 10 times higher than the de minimis levels for insignificant source operations and are consistent with the levels developed by the 112(g) workgroup referred to earlier. Based on current scientific data, HAP emissions above the thresholds specified in Items 1 through 8 above have the potential of causing adverse health impacts. As more risk information becomes available, the Department may adjust these thresholds or modify the list of HAPs that trigger risk assessment.

N.J.A.C. 7:27-22.8(g) requires applicants subject to this section to perform an air quality simulation and risk assessment in accordance with

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the Department's technical manual, Risk Assessment for Operating Permit, which is under development. A draft of this technical manual can be obtained from:

New Jersey Department of Environmental Protection
and Energy
Air Quality Regulation Program
Bureau of Air Quality Evaluation
CN 027
Trenton, New Jersey 08625

This technical manual was developed and adopted pursuant to N.J.S.A. 13:1D-111 to 113, P.L. 1991, c.422, part of a legislative package sometimes referred to as the "Doria bills." According to the statute, the technical manual is, with certain exceptions, "binding upon both the department and the permit applicant," but need not be adopted in accordance with the notice and comment requirements of the Administrative Procedure Act.

N.J.A.C. 7:27-22.8(b) excludes emissions from the combustion of natural gas or commercial fuel oil from the determination of a facility's potential to emit. The Department has examined numerous modeling and health risk assessments performed for these types of facilities in the last five years as part of the preconstruction permit review. These examinations found that the health risk posed by HAP emissions from the combustion of natural gas and commercial fuel oil is extremely small.

N.J.A.C. 7:27-22.8(c) postpones the requirements of this section for equipment subject to a MACT or GACT standard until the application for the operating permit covering the entire facility is submitted. This results in a more comprehensive view of the total facility risk by including the entire facility's HAP emissions.

N.J.A.C. 7:27-22.8(d) sets forth the criteria for risk assessment for renewal applications of operating permits. If the facility's potential to emit any HAP not specified in N.J.A.C. 7:27-22.8(a) is more than 10 tons per year or its potential to emit all HAPs collectively is more than 25 tons per year than a risk assessment for that HAP it must also be included with the renewal application.

N.J.A.C. 7:27-22.8(e) requires applicants for a significant modification to perform air quality simulation modeling and risk assessment if the modification would result in an increase in the facility's potential to emit an air contaminant which exceeds the same thresholds for risk assessment for an initial operating permit. For HAPs without specific thresholds for risk assessment below 10 tons per year of any HAP or 25 tons per year of any combination of HAPS, such assessments are required for significant modifications which commence operation after January 1, 2000. This requirement for significant modifications commencing after January 1, 2000 approximately matches in timing similar modeling and risk assessment requirements needed for the first operating permit renewals.

As discussed above, N.J.A.C. 7:27-22.8(d)2 and 3 and N.J.A.C. 7:27-22.8(e)9 require a risk assessment for remaining hazardous air pollutants in quantities greater than 10 tons per year individually or 25 tons per year collectively. These levels have been established by using EPA's default level of applicability for MACT standards pursuant to Title V of the CAA. The risk assessment triggers set below the 10/25 ton per year levels are based on the acute or chronic toxicity of the HAP.

N.J.A.C. 7:27-22.8(f) provides that risk assessment for a significant modification must evaluate the increase in the potential to emit HAPs, caused by the proposed construction or installation of new source operations or the proposed alteration of existing source operations. The risk from total facility HAP emissions would be assessed at the next operating permit renewal.

N.J.A.C. 7:27-22.8(g) outlines the contents of the Department's draft technical manual on performing risk assessment for operating permits. The technical manual explains in detail how to perform a Level-1 (screening), Level-2 (routine), and Level-3 (refined) modeling and risk assessment analysis. By providing this technical manual, the Department expects to assist those applicants performing the modeling and risk assessment by clearly stating what is required at each level of analysis. Such a document will also aid the Department in its review of modeling and risk assessments submitted in support of operating permit applications.

Pursuant to proposed N.J.A.C. 7:27-22.8(h), all applicants subject to this section have the option to perform a Level-1 analysis, which is a basic risk assessment screening used to determine whether further analysis is necessary. If this analysis shows that impacts are below the health-based thresholds specified in the Risk Assessment for Operating Permits technical manual, then this screening analysis is submitted as part of the application. The level 1 assessment is designed to be done by plant personnel without the aid of a consultant.

If impacts exceed the thresholds in the technical manual for Level-1 analyses, then a Level-2 routine analysis, which involves a more detailed risk assessment using models approved by the Department, is required. If the results are within the thresholds in the technical manual, the Level-2 analyses must be submitted as part of the application. N.J.A.C. 7:27-22.8(i) requires that if risk levels exceed the thresholds set in the technical manual for Level-2 analyses, then a Level-3 refined analysis must be performed in accordance with N.J.A.C. 7:27-22.8(j) and (k) to determine the facility's air quality impact and risk levels. A level 2 analysis requires the use of readily available air quality simulation models which can be run on personal computers. A plant engineer or general environmental consultant should be able to conduct a level 2 analysis.

A Level 3 refined analysis involves a detailed consideration of facility and source emission data. Also, a Level 3 analysis requires that all sources be modelled simultaneously in a spatially correct fashion, while a Level 2 analysis allows each source operation to be modelled independently. Simultaneous source modeling is more resource intensive, but will produce more accurate estimates of facility risk. Level 3 analysis usually requires a specialized consultant in the field of air quality modelling. Most plants should show insignificant effects with a level 1 or 2 analysis and will not require a level 3 analysis. For those plants that require a level 3 analysis, the potential risk to the public justifies the cost and effort. Also, the permittee may elect to take action to reduce risk based on level 1 or 2 assessment, thereby avoiding a level 3 assessment and improving air quality.

N.J.A.C. 7:27-22.8(1) proposes that applicants only need to consider the inhalation route of exposure in their initial operating permit application. The inhalation route is a direct route of exposure and therefore generally poses the most significant risk. The Department may require consideration of other routes of exposure for HAP's which bioaccumulate in subsequent renewal or significant modification applications. N.J.A.C. 7:27-22.8(n) states additional modeling and risk assessment may be required for preconstruction permits. Applicants for preconstruction permits should follow the guidance given in the Department's technical manual on risk assessments for preconstruction permits. A new source of significant HAP emissions will generally require a greater level of detail in their modeling and risk assessment than needed in the operating permit level-1, 2 or 3 analyses.

N.J.A.C. 7:27-22.8(m) requires that any modeling and risk assessment must be performed using the potential to emit. In this context, "potential to emit" means the maximum amount of an air contaminant that is allowed in the operating permit for the equipment being modelled. Use of potential to emit provides an estimate of the maximum potential risk from the facility. The applicant may also analyze the effect of the facility's projected or historical actual emission rate as supplemental information. Use of actual emissions gives a less conservative indication of actual risk.

N.J.A.C. 7:27-22.8(o) provides that use of air quality impact analysis performed within five years of the application for an operating permit may satisfy the requirements of this section; however, prior written approval must be obtained from the Department. This approval would most likely be given for relatively new facilities which have gone through full facility risk assessment as part of the pre-construction permit review process. Risk assessments performed in support of the pre-construction permit application will usually be of a detail equal to or greater than that specified in the technical manual for performing risk assessment for operating permits.

N.J.A.C. 7:27-22.9 Compliance plans

An applicant is required to submit a compliance plan as part of the operating permit application pursuant to 40 CFR 70. A compliance plan incorporates the applicant's statement of how the equipment, source operations, or facility covered by the operating permit will be operated in compliance with all applicable air pollution control regulations during the lifetime of the operating permit. The compliance plan is to include the methods to be used to determine compliance with the applicable requirements, such as, monitoring, recordkeeping, and reporting of emissions or operating parameters of equipment. The Department is authorized, where appropriate, to revise the compliance plan and to incorporate the revised plan into the draft operating permit.

N.J.A.C. 7:27-22.9(a) requires a proposed compliance plan to be submitted as part of each application for an initial operating permit. Proposed N.J.A.C. 7:27-22.9(b) requires that, if any part of the com-

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pliance plan is affected by a renewal, or a significant or minor permit modification, draft revisions to the compliance plan reflecting the changes shall be submitted with the application for Department action.

Proposed N.J.A.C. 7:27-22.9(c) specifies the minimum contents of a compliance plan. Among other requirements, the plan must include a description of the current compliance status of the facility with respect to all proposed permit conditions and all applicable requirements. The methods to be used to verify compliance must be included for any equipment, source operation, or facility included in the permit application, with respect to all applicable Federal and State air pollution control requirements. For example, a reactor may be subject to N.J.A.C. 7:27-16.6. In this case the applicant might claim that the equipment is in compliance with the rule as demonstrated by the results of stack testing. The applicant is required to include a written statement that for the life of the operating permit the reactor will remain in compliance with N.J.A.C. 7:27-16.6. To verify compliance, the applicant might propose an annual test of emissions during the time of operation which has the greatest potential emissions.

Pursuant to 40 CFR 70.5(c)(9), N.J.A.C. 7:27-22.9(c) also requires that the application include a certification of compliance with the New Jersey Toxic Catastrophe Prevention Act (TCPA) and any employee trip reduction rules promulgated by the New Jersey Department of Transportation. The TCPA program is designed to implement section 112(r) of the CAA by identifying companies which handle extraordinarily hazardous substances and ensuring that procedures are in place to prevent the occurrence of devastating accidental chemical releases. The Federal Clean Air Act as amended in 1990, requires New Jersey to develop and implement an Employer Trip Reduction (ETR) Program. This program requires employers of 100 or more employees at a worksite to implement programs that will increase the average passenger occupancy per commuting vehicle during peak periods by at least 25 percent above the average occupancy rate in the area. The details of these two programs are not required to be included in the operating permit; however, the compliance status for both programs must be referenced in the compliance certifications.

N.J.A.C. 7:27-22.9(c)6 and 7 requires the submittal of a compliance schedule if, at the time of applying for the permit, any equipment, source operation, or facility included in the permit application is out of compliance with any State or Federal air pollution control regulation. The schedule is a narrative description of how the facility intends to achieve compliance and specifies sequential milestones leading to compliance. For example, for a surface coating operation subject to N.J.A.C. 7:27-16.5 the schedule may show: (1) engineering study to develop a compliance strategy to be completed by November 15, 1993; (2) apply for permits by December 15, 1993; (3) start-up and evaluate operation by January 15, 1994; and (4) start-up normal operations and final compliance by February 15, 1994. The failure to meet the milestones included in the operating permit subjects the applicant to possible enforcement actions. The compliance schedule requires the submittal of certified progress report and summary compliance reports at least every six months, for the duration of the operating permit.

N.J.A.C. 7:27-22.9(e) clarifies that the compliance plan or schedule approval does not constitute approval or sanction by the Department of the noncompliance. Submittal of a compliance plan does not shield a company from civil administrative penalties for noncompliance with an applicable requirement for the full period of noncompliance.

If in the course of preparing the operating permit application, the applicant determines that any equipment, source operation, or facility is out of compliance, it is the responsibility of the applicant to contact the Department. The enforcement discussions will have two possible results. The Department and the applicant may reach settlement on the alleged violations. Depending on the type, degree and duration of the alleged violations, the settlement may result in an issuance of an administrative order with a required compliance date, stipulation of settlement, or administrative consent order. A negotiated penalty amount will be included in all settlements. If no agreement is reached, the Department will issue an administrative order and civil administrative penalty assessment pursuant to N.J.S.A. 26:2C-1 et seq. and N.J.A.C. 7:27A-3. The submission and approval of a compliance schedule in a permit application does not in any way limit the Department's right to assess penalties consistent with statutory and regulatory authority. Approval of the compliance schedule wll be expedited if it contains a previously agreed upon schedule of corrective action leading to compliance as incorporated into an administrative consent order.

N.J.A.C. 7:27-22.10 Completeness review

This section describes the process for determining when an application for an operating permit application is administratively complete. The minimum information needed to render an application complete is discussed in N.J.A.C. 7:27-22.6, Application contents.

N.J.A.C. 7:27-22.10(a) provides that within 30 days of receipt of an application for an initial operating permit, a renewal, or a minor or significant modification, the Department must make a determination whether the application is administratively complete and notify the applicant of the decision in either case. If the application is incomplete, the Department must notify the applicant that the application is incomplete and specify, in writing, what additional information is required for the Department to review the application. A reasonable date will be specified by which time the applicant must submit the information to the Department.

N.J.A.C. 7:27-22.10(b) establishes three ways whereby an operating permit can be deemed by the Department to be administratively complete. N.J.A.C. 7:27-22.10(b)1, consistent with Part 70, provides that an application is considered to be administratively complete 60 days after the Department's receipt of the application if the Department does not render the application administratively incomplete by issuing a deficiency letter in that time period. Similarly, N.J.A.C. 7:27-22.10(b)2 provides that the administrative completeness review begins the day of submittal of any additional information. If the Department does not notify the applicant within 60 days of its receipt of the information, the application will be considered complete. N.J.A.C. 7:27-22.10(b)3 provides that the date the Department determines the application to be complete and issues a notice of determination of administrative completeness, the application is considered administratively complete.

N.J.A.C. 7:27-22.10(c) and (d) provide that at any time after the submittal of an application, whether or not the application is administratively complete, the Department may request additional information from an applicant. A request for additional information does not change the administrative completeness status of the application. When requesting additional information, the Department shall establish a date by which the information is due to the Department. An applicant may request an extension of time beyond the Department's due date by submitting a written request to the Department.

N.J.A.C. 7:27-22.10(e) states that the Department may deny the application if the applicant does not submit requested information by the date established by the Department. The denial of any application voids any application shield in effect pursuant to N.J.A.C. 7:27-22.7. An applicant may reapply for an operating permit after a previous application is denied. N.J.A.C. 7:27-22.10(f) allows an applicant to reapply for an operating permit at any time. A new application is subject to all of the requirements for an operating permit application, including the necessary permit fees.

N.J.A.C. 7:27-22.11 Public comment

EPA's Part 70 rule requires that the State provide adequate procedures for public notice for operating permit applications for initial permit issuance, significant modifications, and renewals. This includes offering an opportunity for public comment and an opportunity for a public hearing on the draft operating permit.

N.J.A.C. 7:27-22.11(a) and (b) set forth the procedures by which the Department will request comment from the public and affected states on a draft operating permit developed by the Department for an initial operating permit, for a significant modification of an operating permit, for an operating permit renewal, and for a draft general operating permit developed by the Department pursuant to N.J.A.C. 7:27-22.4(a).

This rule does not require public comment on a draft operating permit for a minor modification of an operating permit. However, consistent with Federal requirements, the Department will send the draft operating permit for a minor modification to the EPA and affected states for comment. Having public comment on minor modifications is the subject of a suit by environmental, governmental and industrial organizations against EPA. EPA and the parties in the suit are currently engaging in settlement discussions in an attempt to arrive at streamlined procedures or public comment on minor modifications. It appears possible that EPA may modify its public participation requirements for minor modifications as a result of this suit. If it does, the Department likely will propose revisions to its public participation process to make them consistent with any changes in the EPA rules. In the interim, the

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Department would greatly appreciate comment on the advisability and contents of possible procedures for additional public comment on draft operating permits for minor modifications to operating permits.

N.J.A.C. 7:27-22.11(c) states that the Department will provide public notice of each draft operating permit. Among other requirements, the notice must offer an opportunity for public comment, specify the length of the public comment period, and include the time and location of any public hearing to be held on the draft operating permit. If a public hearing is not scheduled, the public notice must provide the procedures for requesting a hearing.

Additional requirements for public notice procedures are set forth at N.J.A.C. 7:27-22.11(d). Pursuant to this subsection, the Department is required to publish the notice for each draft operating permit in a newspaper which circulates in the area of the facility which is the subject of the permit application. The Department will also mail the notice to those listed on the Department's mailing list for a particular facility. A person may be placed on the Department's mailing list by submitting a written request. Any additional means the Department finds appropriate for assuring adequate notice to the public is also allowed for by this rule.

N.J.A.C. 7:27-22.11(e) and (f) require the Department to hold a public hearing whenever there is a significant degree of public interest in a draft operating permit. If a public hearing is held, notice of such hearing must be given at least 30 days in advance and may be included in the public notice issued for the draft operating permit. A person may request the Department to hold a hearing by submitting a request in writing during the comment period and stating the issues that will be raised at the hearing.

N.J.A.C. 7:27-22.11(g) provides that whenever the Department holds a public hearing in response to a request on a draft operating permit, the public comment period will be automatically extended until 5:00 P.M. on the second State business day following the day of the public hearing. The Department is authorized to further extend the comment period by announcing such extension and its duration at the public hearing.

At a public hearing, the Department may limit the time allowed for oral statements and to require the submittal of written testimony to the Department. This provision will be exercised at public hearings where a significant number of commenters wish to speak. By limiting the oral testimony time of the commenters, the Department will be able to receive oral testimony from all interested commenters. In such a case the Department would request that oral comment be summarized, highlighting key points and that written comments be provided for the entire testimony. A record of all comments and responses will be maintained by the Department for five years.

N.J.A.C. 7:27-22.11(j) requires the Department to notify the air pollution control agency of an affected state before or when publishing a notice of a draft operating permit. Affected states are those states contiguous to New Jersey or within 50 miles of the site of the facility being permitted. Contiguous states are New York, Pennsylvania, and Delaware. States within 50 miles of New Jersey are New York, Pennsylvania, Delaware, Maryland and Connecticut. The Department must accept and consider the comments received from these affected states. If an affected state submits written comments and the Department does not accept the recommendations presented, the Department is obliged to provide the reason to both the affected state and EPA.

N.J.A.C. 7:27-22.12 EPA comment

EPA Part 70 rules require that all proposed operating permits must be submitted to EPA for review before the Department may approve the final operating permit. The review and comment procedures outlined in this section are consistent with the requirements of Part 70. EPA has review and oversight authority over the Department's operating permit program. According to N.J.A.C. 7:27-22.12(b), the Department is responsible for transmitting the proposed operating permit to EPA, along with all supporting documentation, all comments received from the public and from the affected states during the public comment period, and the Department's response to such comments.

A "proposed operating permit" is the version of the operating permit which includes the Department changes made to the draft permit, as a result of public comments. If the EPA does not object to the proposed operating permit within 45 days, the Department may take final action on the permit.

If EPA objects to the proposed operating permit, and the Department fails to revise the permit consistent with EPA's concerns within 90 days after its receipt of EPA's objections, the EPA is authorized to override the Department's action and take final action on the operating permit application.

N.J.A.C. 7:27-22.12(f) provides the public with an opportunity to petition the EPA for 60 days after the expiration of EPA's 45 day comment period if EPA does not object to the proposed operating permit within such deadline. The public may petition EPA, but the petition must be based only on an objection that was raised with reasonable specificity during the public comment period unless: (a) the petitioner demonstrates that it was impracticable for the petitioner to raise the objection during the public comment period, or (b) the basis for the objection arose after the public comment period closed.

Should EPA agree with the petitioner and object to the proposed operating permit before the Department has issued the permit, N.J.A.C. 7:27-22.12(g) prohibits the Department from issuing a final operating permit until the objection is resolved.

If EPA objects to the proposed operating permit based upon the petitioner's concerns, but the Department has already issued the final operating permit, N.J.A.C. 7:27-22.12(h) authorizes EPA to modify, terminate, or revoke the operating permit.

N.J.A.C. 7:27-22.13 Final action on an application

N.J.A.C. 7:27-22.13 specifies the deadlines for final action on an initial operating permit, renewal, significant modification, minor modification, and administrative amendment applications, consistent with EPA's Part 70 rules.

Final action will generally be taken by the Department within 18 months after receipt of an administratively complete permit application for an initial operating permit. However, for affected facilities under EPA's acid deposition control program, the program schedule will be consistent with EPA's rules in response to Title IV of the CAA. Also, the processing may take longer than 18 months if there is a petition to EPA and EPA subsequently objects to the proposed permit.

Upon receipt of an administratively complete application, the Department will take final action within 12 months for renewal, within 90 days for a minor modification, within 180 days for group processing of minor modifications, within 12 months for a significant modification and within 60 days for an administrative amendment. Typical timelines for each of these processes are provided below. The Department seeks comments on these, particularly with respect to balancing the goals of an informed public process and expeditious action on applications for facility modifications.

Tables I through VI set forth typical timelines for processing the various types of operating permit applications. Activity descriptions of the milestones listed in the tables may be found in the Operating Permits Workload Analysis. This report is available for inspection during business hours at the offices of the Department and a copy may be obtained by writing to:

New Jersey Department of Environmental Protection
and Energy
Air Quality Regulation Program
Bureau of Operating Permits
CN027
Trenton, New Jersey 08625

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TABLE I
Typical Initial Operating Permit Timeline

Milestone	Months (Cumulative)
Voluntary Early Submittal	–3
Preliminary Completeness Review	–2
Deadline for the Department's Receipt of Application	0
Administrative Completeness Review	1
Applicant's Response to Application Deficiencies	1.5
Application Determined Complete or Incomplete	2
First Technical Review	4
Applicant's Response to Questions	5
Second Technical Review	6
Applicant's Response to Questions	7
Propose Draft Application	8
Public Comment Ends	9.5
Proposed Permit for EPA Oversight	12.5
EPA Objection (if any)	14
Issue Final Action	15.5

TABLE II
Typical Renewal Operating Permit Timeline

Milestone	Months (Cumulative)
Voluntary Early Submittal	–3
Preliminary Completeness Review	–2
Deadline for the Department's Receipt of Application	0
Administrative Completeness Review	1
Applicant's Response to Application Deficiencies	1.5
Application Determined Complete or Incomplete	2
Technical Review	3.5
Applicant's Response to Questions	4.5
Propose Draft Application	5.5
Public Comment Ends	7
Proposed Permit for EPA Oversight	9
EPA Objection (if any)	10.5
Issue Final Action	12

TABLE III
Typical Significant Modification Operating Permit Timeline

Milestone	Months (Cumulative)
Application for Preconstruction Permit and Modification to Operating Permit	0
Preconstruction Permit Completeness Review	1
Applicant's Response to Application Deficiencies	2
First Technical Review	3
Applicant's Response to Questions	4
Second Technical Review	5
Applicant's Response to Questions	6
Department Proposed Preconstruction Permit, Determines Operating Permit Application is Complete, and Proposes the Draft Operating Permit	7
Public Comment Ends	8.5
Final Preconstruction Permit and Proposed Operating Permit for EPA Oversight*	11
EPA Objection (if any)	12.5
Issue Final Action**	14

Note: *Construction may proceed at risk.
**Operation may begin if modification approved.

TABLE IV
Typical Minor Modification of an Operating Permit Timeline

Milestone	Months (Cumulative)		
	Level 1	Level 2	Level 3
Application for Preconstruction Permit and Modification to Operating Permit	0	0	0
Preconstruction Permit Completeness Review	0.2	0.5	1
Applicant's Response to Application Deficiencies	0.4	1	2
Technical Review	0.6	1.5	3
Applicant's Response Questions	0.6	2.0	4
Department Issues Preconstruction Permit, Determines Operating Permit Application is Complete, and Proposes Operating Permit for EPA Oversight*	0.8	2.5	5
EPA Objection (if any)	2.3	4.9	6.5
Issue Final Action	3.8	5.5	8

Note: Level of permit means the classification of preconstruction permit complexity that is defined in the New Jersey Register notice, 24 N.J.R. 2632(a), 2633, July 20, 1992.

*Construction and operation may proceed at risk.

N.J.A.C. 7:27-22.14 General operating permits

Pursuant to N.J.A.C. 7:27-22.14, the Department may promulgate rules to adopt one or more general operating permits. These permits may cover an entire facility, or one or more source operations at the facility.

The CAA indicates, at §504(d), 42 U.S.C. 7661c(d), that states may issue a general permit which covers numerous similar facilities. Categories of facilities covered by a general permit should generally be homogeneous in terms of operations, processes and emissions. All facilities in the category should have: essentially similar operations or processes; emit pollutants with similar characteristics; and should be subject to the same or substantially similar requirements governing operation, emissions, monitoring, reporting, and recordkeeping.

The primary purpose of the general operating permit is to provide a streamlined means for permitting common, uncomplicated source operations, such as small gas fired boilers or dry cleaning establishments. The conditions of the general operating permit will be at least as comprehensive as the conditions of operating permits developed for other facilities. The benefit of the general permit is that it eliminates the burden on the facility and the Department of case-by-case review of common source operations. Also, the general operating permits serve to provide all persons in the same industry with equal requirements.

For example, the Department may develop an operating permit for gas fired boilers with a capacity of less than 100 million BTU/HR. A set of standard requirements and operating conditions would be established as part of the general operating permit. The general operating permit, in draft, would have a public comment period, as well as the usual EPA and judicial review. Upon approval of the general operating permit, the owner or operator of a facility may apply for authorization to operate its qualified boiler(s) under the terms of the approved general operating permit. If the boilers are the only source operation at the facility, the general operating permit would be the only operating permit for the facility. If there are other regulated sources at the facility, then the general permit conditions for the boilers would be part of the overall operating permit for the facility.

In order to operate under a general operating permit, N.J.A.C. 7:27-22.14(c) requires an owner or operator to explain how the facility meets the criteria for coverage by the general operating permit, and how the facility will comply with all of the conditions in the general operating permit as well as with all of the applicable requirements of subchapter 22.

After adoption of this rule, the Department intends to amend this rule to include specific general operating permits. Source categories that are likely to have general operating permits are: dry cleaners, small boilers firing commercial fuels, metal plating shops, newspaper printers, and asphalt plants. The Department is specifically seeking comment in this proposal on other potential categories for general operating permits. The Department will seek assistance and comment from the relevant trade associations and the environmental community during the development of general operating permits.

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N.J.A.C. 7:27-22.15 Temporary facility operating permits

N.J.A.C. 7:27-22.15 provides for the issuance of a single operating permit to a temporary facility for operations at multiple locations within the State. A "temporary facility" is a facility which may be relocated at least one time within the term of the operating permit. Each location at which the facility will be operated must be specified in the operating permit. This permit does not supersede obligations to comply with all other Federal, State and local laws, rules or regulations. Consistent with 40 CFR 70.6(e), this option is not available for facilities which are affected sources under the EPA acid rain program.

Pursuant to N.J.A.C. 7:27-22.14(b), an operating permit for a temporary facility would require compliance with all applicable requirements. Temporary facilities would also provide written notice to municipal and county officials, as well as the Department, at least 10 days prior to each relocation of the facility. The requirement to notify local officials prior to relocation is not required by Part 70, but is proposed by the Department to ensure that the local officials are aware of potential sources of air pollution in their communities.

Pursuant to N.J.A.C. 7:27-22.24, Significant modifications, a relocation of a temporary facility to a site, other than is authorized in the operating permit, must be processed as significant modification if air quality simulation or risk assessment is required. Pursuant to N.J.A.C. 7:27-22.22, Seven-day-notice change, such a relocation may be processed as a seven-day-notice change if air quality simulation or risk assessment is not required and the relocation otherwise qualifies as such a change.

N.J.A.C. 7:27-22.16 Operating permit contents

An operating permit will include all requirements applicable to each piece of equipment at a given facility. Title V of the CAA also requires that an operating permit specify the means to determine compliance with each applicable standard, regulation, or requirement under the CAA, including the requirements of the SIP. An operating permit for a chemical plant, for example, will contain all relevant provisions, emission limitations, and monitoring and reporting requirements found in N.J.A.C. 7:27-3, 4, 5, 6, 7, 9, 16, 17, 18, 19 and 21; State permits issued pursuant to N.J.A.C. 7:27-8; air toxics standards and regulations promulgated under 42 U.S.C. 7412; new source performance standards (NSPS) promulgated under 42 U.S.C. 7411; prevention of significant deterioration (PSD) or new source review (emission offset) permits; and any other applicable CAA rules. By including all of these provisions in one operating permit, it will be clear to the permittee, the public and the Department what air pollution control requirements apply and whether they are being met.

N.J.A.C. 7:27-22.16 requires the Department to include in operating permits all of the elements required by Part 70. In addition to complying with the mandates of Part 70, N.J.A.C. 7:27-22.16 would incorporate the nuisance prohibition in N.J.A.C. 7:27-22.16(g)8 and operating permit provisions for certain affirmative defenses at N.J.A.C. 7:27-22.16(l). A detailed explanation of these provisions appears in the portions of this summary relating to those subsections.

N.J.A.C. 7:27-22.16(a) specifies that the emission limitations and standards in an operating permit must assure compliance with all applicable requirements. This provision is required by 40 CFR 70.6(a)(1).

40 C.F.R. 70.6(b)(2) requires the Department to designate those terms and conditions in the operating permit which are not required under the CAA or under any of its applicable requirements and are, therefore, not federally enforceable. The Department anticipates that the State rule provisions which prohibit public nuisances, such as portions of N.J.A.C. 7:27-22.16(g)8, are the only State air pollution control requirements which are not Federally enforceable. Currently, EPA is reviewing N.J.A.C. 7:27-8 for inclusion in the SIP. The Department expects that the EPA will designate the nuisance prohibition included in that rule as not being Federally enforceable. Aside from the nuisance provisions, the Department believes all other provisions in the New Jersey Air Pollution Code and in this operating permit program proposal will be considered Federally enforceable. Consequently, while enforcement of the nuisance provisions is limited to New Jersey, all other provisions may be enforced by EPA, as well as by the Department.

In compliance with Part 70.6(a)(1)(i), N.J.A.C. 7:27-22.16(b)2 would require that the operating permit reference the legal authority for each term and condition of the permit. This requirement is satisfied by citations of the State regulations or statutes which make up the SIP or Federal standards for a delegated program such as PSD. These citations will ensure that the permittee, the Department, the EPA, and the public all have a common understanding of the basis for each applicable requirement in the operating permit.

Citations to applicable requirements are also useful in defining the scope of any "permit shield." A permit shield provides that a facility which complies with the conditions of the operating permit shall be deemed to be in compliance with any applicable requirements listed in the permit. In order for the permit shield to be effective in relation to a particular applicable requirement, that applicable requirement must be expressly included in the permit. Additional information on the permit shield can be found at N.J.A.C. 7:27-22.17, as well as in the summary of N.J.A.C. 7:27-22.17 below.

N.J.A.C. 7:27-22.16(b)3 requires that the operating permit identify any difference in form between each permit condition and any applicable requirement upon which the condition is based. For example, an applicable requirement may be stated in terms of a certain unit of measurement. If a different unit of measurement is used for determining compliance with an applicable requirement, the applicant or Department must demonstrate that the alternative limit is at least as stringent as the applicable requirement. This is referred to as an "equivalency determination."

Consistent with Part 70, N.J.A.C. 7:27-22.16(c) specifies that both acid deposition control rules and other requirements applicable to Title IV facilities shall be incorporated into the operating permit and be enforceable by both the Department and EPA.

N.J.A.C. 7:27-22.16(d) requires that if an operating permit contains an alternative emission limit based on an equivalency determination pursuant to N.J.A.C. 7:27-22.3, the permit will also contain provisions to ensure that the alternative emissions limit is quantifiable, accountable, enforceable, and based on replicable procedures. An alternative emission limit allows the State to build additional flexibility into permits. They are sometimes used where a facility is better suited to measure emissions with a different unit of measurement than specified in an applicable requirement. Part 70 stipulates that a state may authorize a facility to meet either the SIP limit or an equivalent limit specified in the operating permit. The determination of what constitutes an equivalent limit must be subject to public comment during the initial permit issuance, renewal process, or significant modification process.

N.J.A.C. 7:27-22.16(e) states that any "preconstruction permit" issued for a facility, or any part thereof, will be incorporated into the facility's operating permit since the conditions of a preconstruction permit are applicable requirements. Most facilities subject to subchapter 22 have been issued preconstruction permits pursuant to N.J.A.C. 7:27-8. Including the requirements of preconstruction permits into operating permit will compile, into a single document, all requirements which apply to a facility. This consolidation will assist both the permittee and the Department in determining compliance with all air pollution control requirements.

N.J.A.C. 7:27-22.16(f) provides for a severability clause in all operating permits to ensure the continued validity of the remaining operating permit requirements in the event of a successful challenge to any portion of the operating permit.

N.J.A.C. 7:27-22.16(g) complies with Part 70.6 by providing standard conditions which the Department will include in all operating permits. These conditions set forth general grounds for enforcement, a declaration that the operating permit does not convey any sort of property right or exclusive privilege, and a requirement that the permittee furnish any information requested by the Department to determine whether cause exists for modifying, revoking and reissuing, terminating the operating permit, or to determine compliance with the operating permit.

New Jersey's general prohibition of air pollution is included at N.J.A.C. 7:27-22.16(g)8. This provision prohibits any person from allowing any "air contaminant," including an air contaminant detectable by the sense of smell, to be present in the outdoor atmosphere in a quantity and duration which is or tends to be injurious to human health or welfare, animal or plant life or property, or which would unreasonably interfere with the enjoyment of life or property. This does not include an air contaminant which occurs only in areas over which the owner or operator has exclusive use or occupancy. This requirement is a standard condition included in permits under the existing preconstruction permit program and is consistent with N.J.A.C. 7:27-5. Including this provision in operating permits will ensure that all permittees are aware that they are liable to state enforcement action for odors or health threatening air contaminants which unreasonably affect others.

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N.J.A.C. 7:27-22.16(g)9 sets forth the rights of the Department to enter and inspect any facility subject to this subchapter.

N.J.A.C. 7:27-22.16(h) provides that, if the Department approves of alternative operating scenarios, the operating permit will contain provisions which detail them. An alternative operating scenario is a plan for operating in one or more alternative ways. In order to incorporate alternative operating scenarios into the operating permit, an applicant must identify all of the proposed alternative operating scenarios in the application.

Pursuant to N.J.A.C. 7:27-22.16(i)2, the alternative operating scenarios, like all other operating procedures, must comply with all applicable requirements. Once incorporated into an operating permit, a person may change between operating scenarios without notifying the Department. N.J.A.C. 7:27-22.16(i)1 requires that changes from one operating scenario to another be recorded in a log.

N.J.A.C. 7:27-22.16(j) and (k) allow provisions for intra-facility emissions trading to be included in the operating permit. See the discussion of N.J.A.C. 7:27-22.28 below for more details on emission trading.

If a permit contains alternative scenarios or emission trading provisions, it will increase the permittee's flexibility because there will be less need for future permit modifications to accommodate different operations at the facility. This is consistent with the mandate in 42 U.S.C. 7661a(b)(6) requiring State programs to include adequate, streamlined, and reasonable procedures for permit actions in these regulations.

Proposed N.J.A.C. 7:27-22.16(l) will implement new legislation enacted early this year (P.L. 1993, c.89), which provides an affirmative defense to certain penalties for air pollution violations. The affirmative defense is included in each operating permit and is available for violations caused by equipment malfunction, equipment startup and shutdown, and necessary equipment maintenance, provided that certain requirements are met, such as proper operation of equipment and prompt notice to the Department. The proposed provision also includes an affirmative defense for violations caused by emergencies. This is consistent with Part 70, which provides an affirmative defense for emergencies under much the same conditions as the New Jersey legislation. A corresponding provision for affirmative defenses is proposed to be added to subchapter 8, at N.J.A.C. 7:27-8.3(m).

N.J.A.C. 7:27-22.16(m) allows for replacement of specifically identified equipment to be scheduled into the operating permit and implemented through the seven-day-notice process. Such replacements are in addition to the replacement of insignificant components, which is also allowed by seven-day-notice. Replacement of significant components, including an entire control device, using the seven-day-notice process is expected to be limited to equipment which may have to be replaced frequently on a normal schedule, or to equipment for which a pre-approved spare is on site.

N.J.A.C. 7:27-22.16(n) requires that all operating permits contain a compliance plan. A compliance plan is developed and submitted as part of an application for an operating permit, renewal, or significant modification and must meet all of the requirements of N.J.A.C. 7:27-22.9.

N.J.A.C. 7:27-22.16(o) requires that each operating permit contain provisions to implement the testing and monitoring requirements of N.J.A.C. 7:27-22.18 and the recordkeeping and reporting requirements of N.J.A.C. 7:27-22.19.

N.J.A.C. 7:27-22.16(p) provides that an operating permit, by request of applicant and approval by the Department, can acknowledge in the permit shield that specific provision(s) of potentially applicable requirement(s) do not apply to the facility, cite any such specific provision(s), and state that compliance with the provision(s) is not required. This provision thereby allows the Department and the permittee to resolve any questions about the applicability of specific requirements without exposing the permittee to the possibility of an enforcement action.

N.J.A.C. 7:27-22.16(r) requires testing methods to be used to determine actual emissions of each significant source operating may be included in the initial operating permit. Otherwise, the methods shall be incorporated into the operating permit upon renewal.

N.J.A.C. 7:27-22.16(s) provides that each operating permit term will be no greater than five years. This is consistent with New Jersey law at N.J.S.A. 26:2C-9 and is consistent with 40 CFR 70.6(a)(2).

N.J.A.C. 7:27-22.17 Permit shield

This proposed section provides for a standard condition, which the Department would include in all operating permits, called a permit shield. A permit shield states that compliance with the conditions of the operating permit will constitute compliance with all applicable requirements which form the basis for the operating permit conditions.

Each operating permit is required by N.J.A.C. 7:27-22.16, Operating permit contents, and by Part 70 to include a list of all applicable requirements for the facility. These applicable requirements are then implemented for the particular facility through specific operating permit provisions. For a facility which is in compliance with all operating permit requirements, a permit shield assures that enforcement action cannot be taken against the permittee for different interpretations of applicable requirements other than the interpretation reflected by the conditions in the operating permit.

Under Part 70, the permit shield is an option which the States may or may not adopt. The Department has proposed that a permit shield be included in all operating permits because this will provide the permittee with the degree of repose that it should be entitled to after going through the rigors of the operating permit process. The proposed shield also encourages development of a thorough operating permit which omits no applicable requirement. N.J.A.C. 7:27-22.17(b) specifies how the scope of the permit shield will be detailed in the operating permit. The shield will only be included in initial operating permits, renewal operating permits, and changes made to an operating permit through a significant modification. Changes made through administrative amendments, changes to insignificant sources, seven-day-notice changes or minor modifications will not be shielded, because such changes will not have been subjected to public comment.

Proposed N.J.A.C. 7:27-22.17(d) provides that any applicable requirement omitted from the permit shall not be covered by the permit shield. Proposed N.J.A.C. 7:27-22.17(e) also provides that the permit shield may be nullified if the terms of the operating permit were based on inaccurate or incomplete information supplied by the applicant. Finally, N.J.A.C. 7:27-22.17(g) specifies that a permit shield does not alleviate any liability by the owner or operator for noncompliance with the operating permit.

It also should be noted that according to N.J.A.C. 7:27-22.9(i), concerning affected Title IV facilities, neither a permit shield nor any other provision in an operating permit may alter or affect the applicable requirements of the acid deposition control program required by Title IV.

N.J.A.C. 7:27-22.18 Source emissions testing and monitoring

As required by 40 CFR 70.6(a)(3), proposed subchapter 22 sets forth testing and monitoring requirements in N.J.A.C. 7:27-22.18.

In order for any rule to be successful in attaining its goal, there must be compliance with that rule. One important goal of the operating permit program is to provide the Department, industry and the public with explicitly defined methods to assess compliance. Testing and monitoring enable both the facility and the Department an opportunity to become aware of pollution problems which may have previously gone undetected and they help ensure that facilities comply with the terms of their operating permits. In addition to prompting awareness of noncompliance, these new requirements will offer a much more accurate indication of the effectiveness of the operating permit program and air pollution control rules.

Stack testing may be required to demonstrate compliance with emission limits specified in the permit. The frequency of emission testing will be specified as a condition of the operating permit. Stack testing can also be required as a condition of modification or renewal of an approved operating permit. Initial testing requirements will be determined in accordance with criteria specified under EPA's Enhanced Monitoring rules (40 CFR 75 Appendix E). Periodic testing may be necessary to reconfirm the emission status of a source after initial compliance has been established. Testing will also be required in order to comply with other Federal regulations for which there are specific test requirements in the Federal rules (for example, NSPS and NESHAPS).

Under N.J.A.C. 7:27-22.18(b) and (c), a permittee must submit for approval a detailed monitoring "protocol" which is a plan for the implementation of the testing and monitoring requirements in the approved operating permit. An operating permit is initially issued with a set of basic testing requirements. Within 90 days after approval of the operating permit, or within a time period specified within the operating permit, the protocol must be submitted by the permittee. The submittal of such protocols is consistent with the current practice for preconstruction permits.

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As set forth in N.J.A.C. 7:27-22.18(c), the protocol must include details of source emission testing and monitoring practices. Each permittee is required to meet all of the specifications of the approved protocol for compliance testing during the term of the operating permit, as required by N.J.A.C. 7:27-22.18(h). A technical manual, "Air Contaminant Testing and Monitoring," is available from the Department, which explains the details of what must be included in the protocol. For a copy, contact the DEPE, Air Quality Regulation Program, CN411, Trenton, NJ 08625-0411, Attention: Bureau of Technical Services, or phone (609) 530-4041. This technical manual also was developed and adopted pursuant to N.J.S.A. 13:10-111 to 113. Thus, as was the case with the technical manual discussed in connection with N.J.A.C. 7:27-22.8(g), it is binding even though it was adopted without notice and comment procedures.

Pursuant to N.J.A.C. 7:27-22.18(d), the Department will inform the permittee of any deficiencies in the proposed protocol and will provide reasonable time for corrections. The permittee must correct the deficiencies and resubmit the protocol to the Department.

As required by N.J.A.C. 7:27-22.18(e), if the operating permit requires source emissions testing, otherwise known as "stack" testing, the permittee must, within 30 days after the approval of the monitoring protocol, schedule a date with the Department for initial testing. This testing must be performed within 180 days after the approval of the operating permit, or in accordance with a schedule included in the operating permit. N.J.A.C. 7:27-22.18(e)3 requires the permittee to submit a test report to the Department within 30 days after the completion of the testing, unless another time is specified in writing by the Department. The report must include relevant operating and production parameters specified in the protocol, as well as all raw field and laboratory data necessary for the Department to verify the findings of the test report. The report must be reviewed and certified, pursuant to N.J.A.C. 7:27-1, by a licensed professional engineer, or by a certified industrial hygienist, as required by N.J.A.C. 7:27-22.18(h). Following this initial testing, the permittee may be required to perform periodic testing if specified in the operating permit.

According to N.J.A.C. 7:27-22.18(g), if the operating permit requires the use of a continuous monitoring system (CMS), which continuously measures and records parameters, the permittee must install, calibrate, operate and maintain all components of the CMS pursuant to all of the specifications in the operating permit and the approved monitoring protocol. CMS will be required to continuously ensure that emissions or operational parameters are continuously in compliance with limits established in the operating permits. Continuous monitoring can be required as a condition of approval of the permit, modification of an existing permit, or upon renewal of an existing permit.

Operating permit applicants may propose alternatives to continuous emission monitoring systems. Allowing alternatives to CEMS is consistent with Federal regulations (40 CFR 75, Subpart E). Such alternatives must be demonstrated equivalent to CEMS in providing an enforceable indication of emissions. The Department encourages applicants to propose alternatives to CEMS, if an appropriate operating parameter can be demonstrated to give a reliable indication of emissions.

N.J.A.C. 7:27-22.18(g) also requires that, within 30 days after approval of the protocol for a CMS, the permittee must schedule a date with the Department for a performance specification test, in order to verify that the CMS is working accurately. The CMS performance specification testing must be performed within 90 days after the installation of the CMS, or the startup of the equipment being monitored, whichever is later, or in accordance with a schedule included in the operating permit.

A report of the performance specification test results must be submitted for CMS within 30 days after completion of the test. This performance specification test report, like the report for source emissions, must also provide the Department with all of the raw field and laboratory data necessary for the Department to reproduce the test results. Pursuant to N.J.A.C. 7:27-22.18(h), the performance specification report must be reviewed and certified by a licensed professional engineer or by a certified industrial hygienist.

N.J.A.C. 7:27-22.19 Recordkeeping and reporting

N.J.A.C. 7:27-22.19(a) requires permittees to maintain records of all required testing and monitoring for at least five years consistent with EPA's Part 70.6. N.J.A.C. 7:27-22.19(b) lists the information which must be included in the records.

Pursuant to N.J.A.C. 7:27-22.19(c), summary reports of all source emissions testing and monitoring required by the operating permit must be submitted by the permittee to the Department at least every six months. This time frame is mandated by 40 CFR 70.6 (3)(iii)(A). If specified in the operating permit, more frequent summary reports may be required.

These summary reports differ from the reports required in N.J.A.C. 7:27-22.18, Source emission testing and monitoring. The testing referred to there for CMS or initial stack testing calls for a more detailed report than the report referred to here. The summary report is a compliance summary and does not include technical backup data. These periodic reports must conform to a format to be developed by the Department and EPA and must be certified pursuant to N.J.A.C. 7:27-1.39 by a responsible official.

N.J.A.C. 7:27-22.19(d) distinguishes between reports for "source emission tests" and reports for "CMS." For a source emissions test, the technical report must be submitted within 30 days after the completion of the sampling. A report for CMS performance and results must be submitted within 30 days after completion of each calendar quarter. The Department has a generic CMS report format, which may be obtained from the Bureau of Technical Services or the Regional Enforcement Offices.

Consistent with 40 CFR 70.6 (a)(3)(iii)(B), N.J.A.C. 7:27-22.19(e) sets forth requirements for reporting any deviation from the requirements of the operating permit. Such deviations must be clearly identified in the required technical and summary reports of testing and monitoring. The reports must contain an explanation as to the probable cause of the deviation(s) and any corrective actions or preventative measures taken. Deviations attributable to emergencies, startup, shutdown and maintenance must be reported. A discussion of emergency, startup, shutdown and maintenance provisions appears in the summary of N.J.A.C. 7:27-22.16(l), concerning operating permit contents.

N.J.A.C. 7:27-22.19(g) distinguishes between reporting those deviations which pose a potential threat to public health, welfare or the environment or which might reasonably result in citizen complaints and those that do not. N.J.A.C. 7:27-22.19(g) requires those deviations which pose a potential threat to public health, welfare or the environment or which might reasonably result in citizen complaints to be reported to the Department immediately. However, if the deviation from the operating permit requirements result in emissions which pose no threat to public health, welfare or the environment that might not reasonably result in citizen complaints those deviations must be reported by 5:00 P.M. on the second business day after the deviation occurred. These provisions are consistent with the current New Jersey Air Pollution Control Act requirement at N.J.S.A. 26:2C-19 and with Part 70.

N.J.A.C. 7:27-22.19(h) authorizes the Department to require a permittee to submit, within 30 days of the Department's request, any records relevant to the operating permits, or to emissions of any air contaminants. This enables the Department to determine whether cause exists for modifying, revoking and reissuing, or terminating the permit. It is also useful in determining compliance with the operating permit.

N.J.A.C. 7:27-22.19(i) states that a permittee must make certain information readily available for inspection at the facility consistent with 40 CFR 70.6(c)(6). N.J.A.C. 7:27-22.19(i)1 through 6 for ready availability of: the operating permit together with any revisions or amendments; an up-to-date diagram of the facility indicating the location of all equipment, control apparatus and stacks; records relevant to the use of any source operation; records documenting any construction, installation, or alteration of any equipment or control apparatus during the term of the operating permit; the date of commencement of operation of any equipment or control apparatus; and any preconstruction permits. All of this information is needed to enable Department inspectors to determine whether a facility is in compliance with its operating permit.

Changes to Operating permits

The proposed new rule include five ways in which a facility may incorporate a change into an operating permit. Subchapter 22 would require that a change be processed as an administrative amendment, a change to an insignificant source, a seven-day-notice, a minor modification, or a significant modification. These categories are consistent with Part 70, and provide a level of review from the Department, EPA, other states, and the public, which correlates to the significance of the change. For example, the changing of a telephone number requires the simple process of an administrative amendment. At this level of change, the permittee notifies the Department of the change contemporaneously with the change being made at the facility. In the case of an administrative amendment, only the Department will review the change. As changes

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at the facility increase in significance, the processing of each change becomes more complex. For example, to implement a significant modification, pursuant to N.J.A.C. 7:27-22.24, the change must be subjected to review from the Department, EPA, affected states, and the public. This tiered system of processing and review provides flexibility in the operating permit program. While all changes are reviewed to some extent, those changes that are simple go through a simple review and those changes that are more significant receive an appropriately more complex review.

N.J.A.C. 7:27-22.20 Administrative amendments

The first tier in the review process is an "administrative amendment." A facility subject to an operating permit may use the administrative amendment process for some changes to information in the permit that have no potential to change emissions from the facility.

There are several changes that a facility may make through the administrative amendment process. Proposed N.J.A.C. 7:27-22.20(b) provides a list of the changes which may be processed as administrative amendments, including changes classified as administrative amendments at 40 CFR 70.7(d) and some changes previously defined as amendments under the existing preconstruction permit program of subchapter 8. These changes are: a change in business, division, or plant name, mailing address or telephone number, company stack designation, plant contact or responsible official. A transfer of ownership or operational control of the facility may also be processed as an administrative amendment. Other requirements also apply to a transfer of ownership. See N.J.A.C. 7:27-22.20(f) and (g) for further details relating to the transfer of ownership of an operating permit facility. Also, the proposed rule provides that correction of typographical errors may be processed as administrative amendments. These typographical corrections are limited by the rule to corrections which do not cause an increase to the emission limits specified in the permit, and which do not require processing as a seven-day-notice change, minor modification or a significant modification.

An administrative amendment may be made at the facility as soon as the permittee has submitted an application for an administrative amendment. An application must be properly submitted on forms obtained from the Department, pursuant to N.J.A.C. 7:27-22.20(e).

Proposed N.J.A.C. 7:27-22.20(g) explains the Department's response to the receipt of an application for an administrative amendment. If the Department finds that the change is not eligible to be processed as an administrative amendment, the Department will notify the permittee. As required by Part 70.7, N.J.A.C. 7:27-22.20(g) provides that the Department will act on the administrative amendment within 60 days after receipt of an application. If the Department approves the administrative amendment, it will incorporate the change into the operating permit.

Proposed N.J.A.C. 7:27-22.20(h) explicitly states that permit shield protection will not be extended to cover any approved administrative amendments. Part 70.7(d)(4) makes extension of the permit shield to cover approved administrative amendments optional, but would require administrative amendments to be subjected to the significant modification process in order to be eligible for the permit shield. This would involve presenting the administrative amendments for EPA and public review, which is an inappropriate use of resources given the insignificance of administrative amendments. In addition, the time required to allow for this review would undermine the purpose of an administrative amendment, which is to process simple changes as quickly and efficiently as possible. For the reasons stated above, the Department has decided that the permit shield will not be proposed to cover administrative amendments. (It notes, however, that if a permittee desires the protection of the permit shield for a change that would qualify as an administrative amendment, it could apply to have that change handled as a significant modification.) Further explanation on the use of the permit shield is available in the proposed text of N.J.A.C. 7:27-22.17, and in the summary of that section above.

N.J.A.C. 7:27-22.21 Changes to insignificant source operations

The Department is authorized by Part 70 (70.4(b)(14) and 70.5(c) to allow a facility to make certain changes to insignificant sources that are not addressed or prohibited by the operating permit, without requiring an operating permit revision.

N.J.A.C. 7:27-22.21(b) sets forth procedures to address changes to the list of insignificant sources provided with the initial operating permit application. See the proposed text of N.J.A.C. 7:27-22.6, Application contents, and the summary of that section above, for a discussion of the term "insignificant source operation." Under the proposed rule, changes to insignificant sources may be implemented without giving notice to either the Department or EPA. At the time of renewal of the operating permit, the permittee must incorporate the changes to insignificant sources into the renewal application.

Although the permittee is not required to give notice of changes to insignificant sources until the time of renewal, the permittee must maintain a log book at the facility which contains a record of changes made to the list of insignificant source operations. This log book must be made available to the Department or EPA upon request. When the permittee submits an application for renewal, it must include all of the changes that were recorded in the log book.

N.J.A.C. 7:27-22.22 Seven-day-notice changes

This proposed section implements section 502(b)(10) of the CAA, 42 U.S.C. 7661a (b)(10), and 40 CFR 70.4(b)(12), which require that the Department allow, upon seven days prior notice to the Department, certain changes within a permitted facility which are not modifications under Title I of the CAA and which do not exceed the emissions allowable under the operating permit. In order to implement such a change, a facility must provide both EPA and the Department with written notification at least seven days before the proposed change occurs; no approval of the change is required. The facility, the Department, and EPA must then attach each notice to their copy of the operating permit. The Department is proposing to implement these mandates of Part 70 through a process it refers to as a seven-day-notice.

As a result of providing this modification process to the permit system, the permittee is allowed more flexibility to implement certain changes which do not increase allowable emissions. The seven-day-notice process covers those changes that are not insignificant enough to go through the administrative amendment process, yet are not so complex or significant that they warrant the review of a minor or significant modification. The seven-day-notice process allows the permittee to implement changes relatively quickly and simply.

Title I modifications include those modifications of provisions of Title I of the CAA that require a preconstruction permit review of a NSPS, NESHAPS, nonattainment area standard or PSD standard. Changes triggering these types of preconstruction permit reviews will not be allowed to be processed as seven-day-notices. A more detailed explanation of the phrase "Title I modifications" is included in the description provided below for N.J.A.C. 7:27-22.24, Significant modifications.

The changes which may be made pursuant to a seven-day notice process are listed at N.J.A.C. 7:27-22.22(c). Through this process, a permittee may make the change seven days after both the Department and EPA receive notice.

For a facility with an approved facility-wide permit, issued pursuant to the New Jersey Pollution Prevention Act (N.J.S.A. 13:10-37), N.J.A.C. 7:27-22.22(c)11 provides operational flexibility by allowing certain changes to be processed as a seven-day-notice instead of a minor modification. However, the criteria specified in N.J.A.C. 7:27-8.17, Exemption for facilities subject to the Pollution Prevention Act, remain in effect. This exemption provides that changes to equipment on control apparatus that do not cause an increase in releases to any media may be made without preconstruction approval. In addition to the above restriction, a Pollution Prevention Plan Modification or a Pollution Prevention Assessment must be made to qualify for the exemption. See N.J.A.C. 7:27-8 for more details on these special provisions.

To apply for a seven-day-notice change the permittee must provide the Department written notice on forms obtained from the Department. Details of what must specifically be provided in the notice is proposed at N.J.A.C. 7:27-22.22(f) and (g). If the Department does not receive the notice at least seven days prior to the change, the permittee will be liable for penalties for each day between the day the change was made and the seventh day after the Department's receipt of the notice. A copy of each seven-day-notice must be attached to the operating permit which is maintained at the facility, as required by N.J.A.C. 7:27-22.22(l).

N.J.A.C. 7:27-22.22(c) lists the changes that the Department is proposing to process a seven-day-notices. For example, replacement of equipment may be processed as a seven-day-notice change for certain nonsubstantial components and in some cases for substantial components if the replacement is authorized in the operating permit. Other examples of seven-day-notice change include certain changes to operating scenarios, intra-facility emissions trading and certain operational changes. These changes and others listed in this section provide for operational

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flexibility minimizing disruptions to facility operations that may be caused by processing these non-complex and environmentally insignificant changes as permit modifications.

N.J.A.C. 7:27-22.22(j) states that upon receipt of a seven-day-notice, the Department will issue an acknowledgement of receipt of the notice and attach the notice to the Department's copy of the operating permit. However, this acknowledgement does not constitute approval of the change. The permittee shall include all such changes in the application for the next renewal of the operating permit, in accordance with N.J.A.C. 7:27-22.30. This allows the permittee to act without waiting for Department approval, while still providing an incentive for the permittee to ensure that the change is actually eligible for the seven-day-notice process, rather than a more complex process such as a minor or significant modification, which would be processed pursuant to N.J.A.C. 7:27-22.23 and 22.24. This is unlikely to be a major issue given a clear list of what can be a seven-day-notice.

If the Department subsequently determines that the change is not eligible for seven-day-notice processing, the permittee is subject to penalties for noncompliance with the operating permit. N.J.A.C.7:27-22.22(k) states that the permittee is also subject to penalties for failure to file an application for a minor or significant permit modification. As with administrative amendments, the Department is proposing a specific list of changes eligible for seven-day-notice so that the likelihood of inadvertent noncompliance should be slight. That likelihood is further reduced by the fact that an applicant can always apply for a modification if its proposed changes does not clearly qualify as a seven-day-notice change.

Pursuant to N.J.A.C. 7:27-22.22(i), the Department reserves the right to impose noncompliance sanctions for the time period between the time the change went into effect and the time the Department determined that the change was ineligible for processing as a seven-day-notice change. This allows the permittee to act without waiting for Department approval, while still providing an incentive for the permittee to ensure that the change is actually eligible for the seven-day-notice change process, rather than a more complex process such as a minor or significant modification, which would be processed pursuant to N.J.A.C. 7:27-22.23 and 22.24.

As provided in N.J.A.C. 7:27-22.22(b), the seven-day-notice process may not be used where the change would require an increase in any emissions limit. This requirement is consistent with Section 70.4(b)(12)(i) of Part 70.

N.J.A.C. 7:27-22.22(c)9 and 10 present seven-day-notice requirements for changes relevant to intra-facility emissions trading approvals. These requirements pertain to those trading provisions which are already included in the operating permit or explicitly provided in a regulation, such as emissions averaging proposed in N.J.A.C. 7:27-19. Part 70 offers the State the option of using this method of implementing operational flexibility. The Department opted to incorporate these provisions into the operating permit program, in order to facilitate intra-facility trading, and thereby allow permittees to comply with applicable requirements in an efficient manner.

N.J.A.C. 7:27-22.22(m) states that the permit shield is not extended to cover changes made pursuant to the seven-day-notice process. Part 70.4(b)(12)(ii)(B) does not permit the Department to extend the shield to cover changes made through this process.

N.J.A.C. 7:27-22.23 Minor modifications

The Federal requirements for the operating permit program implementation of minor modification changes appear in 40 CFR 70.7(e)(2). Proposed N.J.A.C. 7:27-22.23 complies with all these requirements. Pursuant to N.J.A.C. 7:27-22.23(b), a permittee must submit an administratively complete application to the Department prior to making a change which constitutes a minor modification, as detailed in this section. An application becomes administratively complete when the preconstruction permit is approved. Once the preconstruction permit is issued construction and operation may proceed. Pursuant to N.J.A.C. 7:27-22.23(b), compliance with this preconstruction permit is required during this time frame. Until the Department actually approves of the minor modification, the permittee is proceeding at its own risk. Thus, the permittee is subject to sanctions for noncompliance, if the Department or EPA subsequently denies the minor modification. While this is unlikely in view of the technical review of the preconstruction permit, it is a possibility. In the event that the preconstruction permit application is denied, the minor modification application will also be denied.

Changes which may be processed as minor modifications are listed at N.J.A.C. 7:27-22.23(c). This list includes those types of modifications that require a preconstruction permit review to ensure compliance with the Department's regulations but do not have the potential to cause a significant environmental impact. Minor modifications include physical changes to stacks and manufacturing operations which may affect air quality by either increasing the rate or concentration of emissions, but in amounts below those that would render the change a "significant modification." (Significant modifications generally are changes that are more substantial and complex and have the potential to cause a significant environmental impact. A more detailed discussion of "significant modification" set forth below at N.J.A.C. 7:27-22.24.) Equipment replacements, including replacements of substantial components of equipment, are allowed as minor modifications, providing advances in the art of air pollution control are incorporated. Minor modifications may not, under any circumstances, contravene a State or Federal ambient air quality standard, any provision of N.J.A.C. 7:27, or any condition of any approved preconstruction permit.

Information required in the application for a minor modification is set forth at N.J.A.C. 7:27-22.23(f) and (h). Pursuant to N.J.A.C. 7:27-22.23(i), the applications for the minor modification and the preconstruction permit must be submitted simultaneously. This allows both to be processed in a coordinated manner as discussed below. The Department is developing a combined application form for these applications to further streamline the process.

(Note: N.J.A.C. 7:27-22.23(g) has been reserved for future use in this proposed rule.)

Pursuant to N.J.A.C. 7:27-22.23(k), within five working days after an application is determined to be administratively complete, which is usually the date of issuance of the preconstruction permit, the Department will notify the EPA and any affected state that the application is complete and provide a copy of the preconstruction permit conditions. Pursuant to N.J.A.C. 7:27-22.23(n), the Department then allows for comments from these parties.

Pursuant to N.J.A.C. 7:27-22.23(l), within 90 days after the application is administratively complete, or 15 days after the completion of the 45 day review period, whichever is later, the Department may approve or deny the modification. However, if the Department determines that the modification requires processing as a significant modification, the application for a minor modification will not be denied but will be terminated. In that case, the applicant would be required to proceed through the significant modification process before implementing the proposed change. As a final alternative, the Department may also revise the applicant's suggested draft operating permit and approve the modification as revised.

If the Department approves of the minor modification, the Department will incorporate the change into the operating permit and submit a copy of the revised portion of the operating permit to EPA pursuant to N.J.A.C. 7:27-22.23(m). The Department must also explain the reasons for not accepting any recommendations submitted by EPA or any affected state per N.J.A.C. 7:27-22.23(o).

In the event that a permittee wishes to implement more than one minor modification, the permittee may request that all of the modifications be group processed. Information on group processing is set forth at N.J.A.C. 7:27-22.23(p), (q), (r), (s) and (t). Group processing provides the parallel tracking and review of several minor modifications at the same time. This provision avoids redundancy of processing and review of multiple applications, thereby reducing the administrative and technical burdens to both the Department and the applicant.

N.J.A.C. 7:27-22.24 Significant modifications

Significant modification procedures are used for applications requesting permit modifications that do not qualify as administrative amendments, changes to insignificant source operations, seven-day notices, or minor modifications. Changes which constitute significant modifications are usually complex and consequential. Therefore, the level of review is more thorough than other permit revisions. N.J.A.C. 7:27-22.24(b) lists changes which must go through the significant modification process.

The CAA and Part 70 require that any change which would be a "modification under ... Title I" must be processed as a significant modification. However, rather than simply using the broad, somewhat ambiguous phrase used in the CAA and Part 70, the proposed rule specifically identifies the subject changes as those that would cause the facility to be subject to requirements of the emission offset rule, NSPS, NESHAPS, PSD or Federal visibility requirements. Further, any changes

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that would constitute "modifications" under the foregoing requirements would require significant modification of the facility's operating permit. The Department notes that for emission offset and PSD a change would generally have to cause a significant increase in emissions to constitute a "modification." For NSPS, any increase in emissions of a regulated air pollutant constitutes a modification. For NESHAPS, a major increase of HAP emissions constitutes a modification. In addition to Title I modifications, EPA requires that certain other changes be processed as significant modifications. Specifically, relaxations of the compliance plans or monitoring, recordkeeping or reporting requirements must be handled as significant modifications. Other types of significant modifications include variances from emission limits and case-by-case determinations of emission limits, such as alternative nitrogen oxide emission limits granted pursuant to proposed N.J.A.C. 7:27-19. Some new intra-facility emissions trading provisions will also be processed as significant modifications.

All of the above changes are mandatory significant modifications pursuant to Part 70. The Department does not intend to expand EPA's requirements for significant modifications through this rule. However, the Department has attempted to clarify what significant modifications are, especially with respect to EPA's reference to modifications "under Title I." The Department especially encourages comments on this section directed at providing further clarification and ensuring that all mandatory significant modifications have been included. (It notes that EPA has attempted some clarifications of this term in a footnote to its 1991 operating permit proposal. See 56 F.R. at 21746 (May 10, 1991).)

In order to satisfy the requirements of the significant modification process, a permittee must submit an application on Department forms, along with any necessary supplemental information. This application is then subject to all of the procedural requirements for an initial operating permit, including review by EPA, affected states, and the public.

40 C.F.R. 70.5(a)(1)(ii) requires an applicant to obtain a preconstruction permit prior to commencing construction and obtain a fully approved significant modification to their existing operating permit prior to operation of the modified equipment. The exception to this is a significant modification made prior to the approval of an operating permit for an existing facility. In this case, the existing preconstruction permit process applies, including PSD and emission offset rules, if applicable, and the equipment may be operated under an operating certificate until an operating permit is issued. For such modifications the Department will issue an operating certificate along with the preconstruction permit to give operating authority until the operating permit is approved.

An administratively complete application for a significant modification includes any required preconstruction approvals. To be timely, an application for a significant modification should be submitted at least one year before the planned commencement of operation of any source operation proposed to be modified. See the typical timeline for processing significant modifications provided in the discussion of N.J.A.C. 7:27-22.13. This is consistent with the current time required to process PSD and emission offset affected permit applications which are expected to represent most of the significant modifications.

Permittees have the option to submit both the application for a preconstruction permit and the application for the significant modification at the same time. If the applications are submitted simultaneously, the Department will process both at once. However, the application for the significant modification will not be deemed administratively complete until the preconstruction permit is approved, and has all application content requirements for an initial operating permit, set forth in N.J.A.C. 7:27-22.6, relevant to the proposed modification. If the preconstruction permit is denied, then the significant modification will also be denied. Once the preconstruction permit is approved construction can begin.

N.J.A.C. 7:27-22.25 Department initiated operating permit modifications

Part 70 requires that each operating permit include provisions specifying the conditions under which the permit will be reopened prior to its expiration. N.J.A.C. 7:27-22.25 sets forth the triggering events which will call for an operating permit to be revoked, or reopened and modified.

N.J.A.C. 7:27-22.25(b) would require a permittee, when asked by the Department in writing, to give the Department any relevant air pollution control information requested in order to determine whether cause exists for revoking, or reopening and modifying the operating permit.

N.J.A.C. 7:27-22.25(c) and (d) explain that prior to a reopening, the permittee will be given at least 30 days to make application to change the operating permit as required through one of the processes available. These processes are administrative amendments, seven-day notices, minor modifications, and significant modifications. A shorter time frame may be provided if continued operation of the facility, under its current operating permit, may adversely affect human health, or welfare, or the environment. If the permittee fails to act within the deadline, the Department will reopen the permit and process the modification as a significant modification. This means, for example, that if a change could have been processed through the relatively simple seven-day notice process, with timely action by the permittee, the lack of timely action will make it necessary to go through a significant modification process. As a result, a change which could have been made in seven days, would instead have to proceed through the public and EPA review process wait for a public hearing on the issue before it may be implemented.

As required by Part 70, N.J.A.C. 7:27-22.25(e) lists the events which trigger the Department to reopen and modify the operating permit. Where additional applicable requirements need to be incorporated into the operating permit, or where those requirements which were already applicable have changed, the operating permit must be revised to reflect these changes. Also, the operating permit will be reopened and modified if either the Department or EPA determine that the operating permit contains a material mistake or that inaccurate statements were made in establishing emissions standards, limitations or other provisions or conditions of the permit.

Pursuant to N.J.A.C. 7:27-22.25(f), no reopening is required if the date that the requirement will become applicable is later than the date on which the operating permit is due to expire. In this case, such changes will be incorporated into the renewal. However, if the original operating permit or any of its provisions and conditions have been extended pursuant to an application shield, a reopening and modification of the operating permit will still be necessary. Although Part 70 maintains that the Department may refrain from incorporating new applicable requirements into operating permits with fewer than three more years remaining, the Department has chosen to incorporate newly promulgated applicable requirements into all operating permits, regardless of expiration date. This enables the Department to incorporate the new provisions into all subject operating permits at the same time, thus conserving resources overall.

As required by Part 70, N.J.A.C. 7:27-22.25(g) specifies that the Department will take final action on a modification to incorporate an applicable requirement no later than 18 months after the promulgation of the applicable requirement. This complies with the intent of Part 70 that applicable requirements be expeditiously incorporated into operating permits.

As proposed in N.J.A.C. 7:27-22.25(h), the permittee shall comply with both the applicable requirements which apply to the facility and the provisions of the current operating permit, during the period that the permit is reopened.

N.J.A.C. 7:27-22.25(i) would require the Department to revoke an operating permit if the Department determines that the continued use of the facility, pursuant to the permit, poses a potential threat to public health, welfare, or the environment, or that air emissions would unreasonably interfere with the enjoyment of life and property. This provision is currently included in the preconstruction permit program under subchapter 8 and is consistent with the New Jersey Air Pollution Control Act.

Pursuant to N.J.A.C. 7:27-22.25(j), (k) and (l), if the Department receives notice from EPA indicating that EPA has found cause to revoke, or to reopen and modify an operating permit, the Department must respond within 90 days with a proposed determination. This proposed determination will be forwarded to both EPA and the permittee and will detail the actions that the Department plans to take in order to accommodate EPA's notice. Should the Department determine that more information is needed from the permittee, or that the permittee needs to submit an application for a minor or significant modification, EPA may authorize the Department to extend 90 day deadlines for issuing a proposed determination. If EPA either approves of the proposed determination or fails to act on it, within 90 days of receipt, the Department shall proceed to finalize the proposed determination according to procedures for finalizing a significant modification. If within 90 days after receipt, EPA objects to the proposed determination, the Department then has 90 days in which to resolve EPA's objection and to terminate, modify, or revoke and reissue the operating permit in accordance with EPA's comments. If the Department fails to submit a proposed determination within the time frame above, or fails to resolve

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any EPA objection, then EPA may act. However, EPA rules require that the permittee must receive 30 days notice and an opportunity for comment and a hearing, prior to EPA taking action.

N.J.A.C. 7:27-22.25(m) states that the provisions of this section do not allow the extension of a compliance deadline in any applicable requirement. Implementation of applicable requirements must proceed in accordance with any deadlines established in the requirement.

N.J.A.C. 7:27-22.26 MACT and GACT standards

N.J.A.C. 7:27-22.26 establishes New Jersey's procedure for implementing the Federal requirements that apply to certain source operations and facilities which must comply with the MACT and GACT standards that are established in Title III of the CAA. Sources that may be affected by this section are those which may emit hazardous air pollutants (HAPs). These requirements are set forth at Title III of the CAA amendments of 1990, including section 112 of the CAA, 42 U.S.C. 7412.

The following definitions have been included in subchapter 22 as a result of this section:

"MACT standard" or "Maximum achievable control technology standard" is an emission limitation established by EPA's Emission Standards Division pursuant to section 112 for a specific industry or process type which emits major quantities of one or more HAPs. MACT standards will be proposed over a 10 year period for more than 150 source categories pertaining to approximately 15 industrial groups.

"GACT standard" or "Generally available control technology" standard is an emission limitation established by EPA's Emission Standards Division pursuant to section 112 for a specific industry or process type which emits less than major quantities of one or more HAPs. In the context of the GACT standard, these smaller facilities or source operations are known as area sources. GACT standards will be proposed by EPA for approximately 15 area source categories.

"Major hazardous air pollution (HAP) facility" is a major facility, or part of a facility, which emits or has the potential to emit:

1. Ten tons or more per year of any HAP; or
2. Twenty-five tons or more per year of any HAPs, collectively.

"Area source" is a term used in conjunction with the GACT standards. It is defined as a stationary source that is not a major HAP facility; that is, it is smaller than a major source as defined in Title III of the Clean Air Act Amendments of 1990.

"Construction of a major HAP facility" means the fabrication, erection or installation of a new major HAP facility or of a new source operation at an existing facility if the new construction by itself would constitute a major HAP facility.

"Reconstruction of a major HAP facility" means the replacement of components of a major HAP facility to such an extent that the fixed capital cost of the new components exceeds 50 percent of the fixed capital cost that would be required to construct a comparable facility.

"Modification of a major HAP facility" means any physical change in, or change in the method of operation of, a major HAP facility which increases HAP emissions by more than an amount which will be defined by EPA.

N.J.A.C. 7:27-22.26(a), (b), (c) and (d) describe MACT and GACT standards, identify facilities that are subject to these standards, and indicate that these standards will be applied through an operating permit. There are two types of MACT standards. One type of MACT standard is established when EPA promulgates a rule. The second type of MACT standard, case-by-case MACT, is proposed by the applicant and approved or modified by the Department as part of a permitting process.

The case-by-case MACT standard is developed under any of the following situations:

1. Construction of a major new HAP facility (either at a site which had no previous HAP emissions or at an existing facility);
2. Reconstruction of a major HAP facility;
3. Modification of a major HAP facility, when the changes could increase the facility's actual emissions of any HAP by more than a de minimis amount to be defined in 40 CFR 63 (the Federal regulation which implements section 112(g) of Title III of the CAA). It should be noted that this proposal does not include provisions for offsets now being considered by EPA which could allow some sources to avoid case-by-case MACT determinations. Once the Federal rules relevant to section 112(g) of the CAA are adopted, the Department will review the offset provisions to determine how they might be incorporated into the New Jersey program; or
4. If EPA fails to promulgate a specific MACT standard by the deadline proposed by EPA and published in the Federal Register on September 24, 1992 at 57 F.R. 44147-44158 which would have applied to the facility or source operation(s).

N.J.A.C. 7:27-22.26(e) sets forth the schedule for applying for an operating permit to incorporate MACT and GACT standards that are promulgated by EPA. The schedule set by EPA in the standard itself will be followed, unless EPA fails to explicitly set a schedule for submitting an application. If this should happen, then the operating permit application should be submitted either 12 months after EPA's promulgation date or 24 months prior to the date that the facility must comply with the standard, whichever date comes earlier.

N.J.A.C. 7:27-22.26(f) sets the deadline for application for an operating permit to incorporate any case-by-case MACT standard. Such an application must be submitted at least 18 months before commencement of operation of a new or reconstructed source operation or facility. This same deadline applies for a modification that increases HAPs emissions in major amounts. The review would be pursuant to the procedures for a significant modification, whereby construction can begin upon issuance of the preconstruction permit, and operation can begin upon issuance of the operating permit modification. In the case where there is a modification that is less than 10 tons per year for a single HAP or 25 tons per year for all HAPs, an application must be submitted prior to commencement of operation of the modified source. The smaller modifications have a shorter schedule becuase they only require a minor modification to an operating permit. In the case of minor modification, both construction and operation can begin upon issuance of the preconstruction permit. Finally, when a case-by-case MACT standard is determined because of EPA's failure to promulgate a MACT standard, then an application to incorporate the standard must be submitted within 18 months after the deadline for EPA promulgation.

N.J.A.C. 7:27-22.26(g) includes the procedures for incorporating a MACT or GACT standard into an operating permit. If a facility does not have an operating permit at the time a MACT or GACT standard promulgated by EPA becomes applicable to the facility or source operation, an owner or operator must apply for an initial operating permit. The initial operating permit in this case would only cover the equipment that is subject to the MACT or GACT standard. The operating permit application for the remaining sources at the facility would be submitted at the time required by the schedule in N.J.A.C. 7:27-22.5, Application procedures for initial operating permits.

In the case where a facility already has an operating permit at the time a MACT or GACT standard promulgated by EPA becomes applicable, the owner or operator must take one of two actions. If the facility is already meeting the requirements of the standard, then the owner or operator should amend their operating permit pursuant to a seven-day-notice. If the facility is not yet meeting the requirements of the new standard, then the owner or operator should apply for a significant modification.

N.J.A.C. 7:27-22.26(h) describes the procedures for incorporating a case-by-case MACT standard into the operating permit. Modifications that result in emissions increases that are less than 10 tons per year for a single HAP or 25 tons per year for all HAPs combined are required to apply for a minor modification to the facility operating permit. These changes at the facility will not be subject to public notice. All other case-by-case MACT decisions must be incorporated into the operating permit by means of a significant modification, which will be subject to public notice. The distinction between a minor modification and a significant modification is consistent with the distinction drawn by N.J.A.C. 7:27-22.23 and 22.24.

N.J.A.C. 7:27-22.26(i) and (j) specifies that for case-by-case MACT standard determination, the owner or operator is responsible for proposing standards for Department review and approval. This is because case-by-case MACT is required for some sources even where no generic MACT standard has been adopted. As required by section 112(d) and (g) of the CAA, all case-by-case MACT standards must represent the maximum degree of emission reduction achievable by the facility, taking into consideration the cost of achieving such reductions and any non-air quality health and environmental impacts and energy requirements. Further, new or reconstructed sources must demonstrate an emission level which is at least as stringent as the lowest emission level achievable in practice by the best controlled similar facility. This is analogous to lowest achievable emission rate (LAER) requirements for new sources of nonattainment pollutants which standard the Department has had substantial experience in applying.

Sources which increase HAP emissions by more than de minimis amounts and existing sources for which EPA fails to promulgate a MACT

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standard will be required to meet emission limitations that are at least as stringent as those achieved by the incorporation of advances in the art of air pollution control. This concept, known as "state-of-the-art" review, is already a part of the New Jersey preconstruction permit program. It is equivalent to the "achieved in practice by the best controlled similar source" standard required by section 112(d)(3) of the CAA. Modified sources in New Jersey are already required to demonstrate that new or altered equipment incorporates advances in the art of air pollution control for the kind and amount of air contaminant emitted. State-of-the-art encompasses the Federal requirements for best available control technology (BACT) under the PSD program and lowest achievable emission rate (LAER) under the emission offset program. The concept of equating state-of-the-art to the standard required by section 112(d)(3) of the CAA will reduce the burden on industry since the state-of-the-art standard has long been applied in New Jersey. This is especially true for modified sources requiring case-by-case MACT. The Federal requirement for case-by-case MACT for modified sources requires a determination of the average of the top 12 percent similar controlled sources on a nationwide basis. The current state-of-the-art requirement for modified sources is that they use the best control available for a similar modified source. The Department's current rule thereby eliminates the necessity of reviewing a database that would be difficult or cumbersome to access for the purpose of trying to determine the top 12 percent best controlled sources.

N.J.A.C. 7:27-22.26(k) sets the deadlines for complying with a MACT or GACT standard that has been promulgated by EPA. If the Federal regulation contains a compliance schedule, then it must be followed. In the event that a compliance date is not specified by EPA and the subject facility has not commenced operation by the date of EPA's promulgation of the applicable MACT or GACT standard, compliance with the standard must be achieved by the time the facility commences operation. For a facility that has already commenced operation prior to EPA's promulgation date, compliance with the applicable MACT or GACT standard must be achieved no later than three years after promulgation of the MACT standard.

N.J.A.C. 7:27-26(l) allows the Department to grant a six-year extension to a facility for complying with a MACT or GACT standard if there was sufficient early reduction of HAP emissions of at least 90 percent of all non-particulate HAP emissions or 95 percent of all particulate HAP emissions prior to EPA promulgation of the applicable standard. This is consistent with EPA rules for early reductions. See 40 CFR Part 63.

N.J.A.C. 7:27-22.26(m) outlines the procedures that an applicant for an early reduction extension must follow to establish a baseline of emissions from which the applicant will demonstrate a 90 percent reduction of non-particulate HAP emissions or 95 percent reduction of particulate HAP emissions. N.J.A.C. 7:27-22.26(n) states that an approved early reduction compliance extension plan must be incorporated into an operating permit for the facility. N.J.A.C. 7:27-22.26(o) states that early reduction compliance extension is limited to equipment or process based on MACT or GACT standards. If EPA promulgates a standard that is health based, the extension does not apply and the facility is subject to the standard in accordance to the schedule set by EPA. These provisions are consistent with Title III of the CAA and EPA's implementing rules.

N.J.A.C. 7:27-22.26(p) sets the schedule for compliance with a case-by-case MACT standard. A modified, newly constructed or reconstructed facility must comply by the date of commencement of operation of the equipment subject to the standard. For a facility subject to a case-by-case MACT determination because EPA has not promulgated a standard compliance must be achieved as soon as practicable. However, compliance must occur no later than three years after the date when EPA's promulgation of MACT standard was due.

N.J.A.C. 7:27-22.26(q) states that if a facility begins construction or reconstruction after EPA proposes an applicable MACT or GACT standard, but before the standard is promulgated, then the source has up to three years to comply with the standard.

N.J.A.C. 7:27-22.26(r) states that if a facility has installed best available control technology (BACT) or lowest achievable emission rate (LAER) control on a source operation which emits a HAP prior to EPA's promulgation of an applicable MACT standard for the same HAP, compliance with the MACT standard is not required until five years after the date of installation of the control equipment. This allows a facility that has installed the best possible controls at the time of construction of the equipment at least a five year period to gain the benefits of that installation free from the requirement of retrofitting new control devices.

N.J.A.C. 7:27-22.27 Alternative operating scenarios

This section provides for operational flexibility in operating permits by allowing approval of an operating permit with multiple operating scenarios. This section, consistent with Part 70, requires certain information in the permit application for all alternative operating scenarios at a facility. Upon approval of the alternative operating scenarios, a facility may switch from one operating scenario to another without notification to the Department.

N.J.A.C. 7:27-22.27(b) states that alternative operating scenarios which cause an exceedance of any maximum allowable limits established within approved scenarios in the operating permit are prohibited. According to this section, a permittee may add alternative operating scenarios to their operating permit through established procedures.

N.J.A.C. 7:27-22.27(e) and (f) establish the minimum information required to be submitted to the Department, when an applicant or permittee seeks authorization for an alternative operating scenario.

Facilities authorized to operate under one or more alternative operating scenarios must maintain a log, by date, of which operating scenario was run.

N.J.A.C. 7:27-22.27(d) requires the permittee to ensure that the operation of equipment under an alternative operating scenario meets all permit conditions, applicable requirements, and the requirements of this Chapter 27.

N.J.A.C. 7:27-22.28 Intra-facility emissions trading

N.J.A.C. 7:27-22.28 would allow facilities to trade emission increases and decreases between source operations within the facility under certain conditions. Two kinds of trading are included in the EPA Part 70 rule, and both are included in this proposed rule. One involves setting an emissions cap for a group of source operations as part of the operating permit process. An example would be a group of boilers for which the applicant agrees to cap overall fuel use and emissions at a level lower than applicable requirements require so as to keep total emissions low enough to avoid triggering a PSD permit process but at the same time maintain a reasonable degree of operational flexibility. In this case, public comment would be sought on the trading as part of the operating permit issuance process. The other kind of emission trading would implement explicit emissions trading provisions already approved pursuant to specific provisions in a rule which is part of the approved state implementation plan (SIP). An example would be nitrogen oxides emission averaging included in proposed N.J.A.C. 7:27-19. In this case public comment was sought in connection with the promulgation of the rule. This section describes the criteria for which trading may be allowed in an operating permit or by seven-day-notice.

N.J.A.C. 7:27-22.28(a) requires that intra-facility emissions trading conform with the Federal emission trading policy published in the Federal Register, volume 51, number 233 or with any economic incentive program guidance issued by EPA, and be specifically approved in an operating permit. This is consistent with Federal emissions trading requirements.

N.J.A.C. 7:27-22.28(b) requires that intra-facility emission trading be limited to a group of source operations which are proposed by the applicant and approved by the Department.

N.J.A.C. 7:27-22.28(c) would allow a permittee to seek approval of intra-facility emissions trading in applications for an initial operating permit, a significant modification, or a renewal application. If a specific trading provision has been included in another rule, that rule may specify that the trading can be incorporated into the operating permit by a seven-day-notice.

N.J.A.C. 7:27-22.28(e) would allow certain modifications to emission trading provisions in an operating permit to be made by seven-day-notice. Such changes would not increase emissions and would have to qualify as seven-day-notice changes for the individual source operations having changed.

N.J.A.C. 7:27-22.28(d) specifies the minimum information required in the application.

If the Department approves intra-facility trading in the operating permit, N.J.A.C. 7:27.28(f) requires the Department to establish in an operating permit a Federally enforceable cap on the aggregate emissions for the group of source operations included in any approved intra-facility emissions trading. The Department must also issue conditions which enable the Department to verify facility compliance with the emissions cap.

N.J.A.C. 7:27-22.28(g) incorporates the Federal requirement that the Department can not approve any intra-facility emissions trading which

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includes equipment for which any applicable requirement requires case-by-case approval of any change in emissions, unless such case-by-case approval has already been issued by the Department and EPA.

N.J.A.C. 7:27-22.28(h) allows intra-facility emissions trading which is included in the SIP and approved in accordance with the detailed procedures included in the relevant state rule. Consistent with Part 70.4(b)(12)(ii), such trading, if already approved consistent with the procedures in the SIP, can under certain circumstances be appended to the operating permit with a seven-day notice, or through a minor or significant modification as appropriate.

N.J.A.C. 7:27-22.28(i) requires that the permittee maintain a log at the facility for recording emissions for the source operations within an emission trading cap and demonstrating compliance on a daily basis.

N.J.A.C. 7:27-22.28(j) requires the permittee must ensure that operation under an intra-facility emissions trading program meets all permit conditions and applicable requirements for any individual source operation, even if that source operation is part of a group of source operations within an emissions trading cap.

N.J.A.C. 7:27-22.29 Affected Title IV facilities

This section includes the proposed requirements for facilities subject to Title IV of the Clean Air Act, 42 U.S.C. 7651 to 7651o, when applying for an operating permit.

N.J.A.C. 7:27-22.29(a) states that applications for operating permits for facilities subject to Title IV of the CAA shall be processed in accordance with the acid deposition control provisions of the Act and the Federal rules at 40 C.F.R. 72.

According to N.J.A.C. 7:27-22.29(b), any portion of an application which is being submitted pursuant to the acid rain provisions of 40 CFR 72, including those portions of the compliance plan pertaining to acid rain requirements, must include nationally standardized forms consistent with the EPA memorandum from Lydia Wegman, Deputy Director of the Office of Air Quality Planning and Standards to the Director, Air Division, Regions I-X, titled "Title IV-Title V Interface Guidance for States" dated May 21, 1993. The memorandum is available, and the forms will be available, from the Department at New Jersey Department of Environmental Protection and Energy, Air Quality Regulation, Bureau of Air Quality Engineering, 401 East State Street, CN027, Trenton, NJ 08625, upon EPA's finalization.

N.J.A.C. 7:27-22.29(c) states that for an application for an initial operating permit for a facility subject to Title IV to be administratively complete, such applications shall include all information required by the application forms, including the name and address of any designated Title IV representative, as defined in N.J.A.C. 7:27-22.1.

Pursuant to N.J.A.C. 7:27-22.29(d), the compliance plan for a facility subject to Title IV shall meet all the requirements of N.J.A.C. 7:27-22.9, Compliance plans, except where these requirements are superseded by the acid deposition control requirements set forth in the Clean Air Act or by any applicable provisions of 40 C.F.R. 72.

N.J.A.C. 7:27-22.29(e) states that the Department will take final action on an application for an operating permit, an operating permit renewal, a significant modification or a minor modification, for a facility subject to Phase II Title IV requirements within the deadline set forth in the acid deposition control regulations.

As set forth in N.J.A.C. 7:27-22.29(f) and (g), a facility which is subject to Title IV faces certain restrictions under the operating permit program. In particular, affected Title IV units subject to the acid deposition control requirements of the CAA are not eligible for authorization to operate under a general operating permit consistent with 40 CFR 70.6(d)(a). Also, the Department is not authorized to issue an operating permit which authorizes temporary operations in more than one location to an affected Title IV facility, consistent with 40 CFR 70.6(e).

As required by Federal law, N.J.A.C. 7:27-22.29(h) provides that when the CAA acid deposition control requirements apply to a facility, the operating permit will contain a condition which prohibits emissions exceeding the lawfully held "allowances." An "allowance" is a unit authorizing sulfur dioxide emissions pursuant to the acid deposition control program. (As noted earlier in the summary of N.J.A.C. 7:27-22.16(c), the core rules for this program were promulgated by EPA on January 11, 1993. See 40 CFR 72, 73, 75, 77, and 78).

As required by 40 CFR 70.6(f)(3)(iii), N.J.A.C. 7:27-22.29(i) states that neither a permit shield nor any other provision in an operating permit shall alter or affect the applicable requirements of the acid deposition control program.

Pursuant to N.J.A.C. 7:27-22.29(j), the Department shall reopen and modify an operating permit for a facility subject to Title IV if additional requirements become applicable to the facility under the acid deposition control program. However, consistent with 40 CFR 70.7(f)(1)(ii), the Department shall not reopen an operating permit for a Title IV facility if excess emissions offset plans are to be incorporated into the operating permit after they are approved by EPA, or for increases in emissions that are authorized by allowances acquired pursuant to Title IV, as long as these actions do not require an operating permit revision under any other applicable requirement.

N.J.A.C. 7:27-22.30 Renewals

This section sets out the requirements for renewal of an operating permit. N.J.A.C. 7:27-22.30(b) requires the submittal of an administratively complete application to renew an operating permit 12 months prior to expiration.

N.J.A.C. 7:27-22.30(d) sets forth the required contents of a renewal application. The renewal application must include a summary of all changes that have been incorporated into the operating permit as administrative amendments, minor modifications and significant modifications, during the past five year permit term. Any changes submitted as seven-day-notice changes over the previous permit term should also be reflected in the application. Finally, any additional changes which the permittee wishes to incorporate into its operating permit may be submitted to the Department with all of the information required by initial operating permit procedures at N.J.A.C. 7:27-22.5. N.J.A.C. 7:27-22.30(d) also requires a summary of any testing or monitoring done during the term of the permit.

The Department requires that applicants submit a draft operating permit which reflects any change in the facility or its operation since the last operating permit issuance and proposes requirements and conditions that the applicant believes should be in its operating permit. If the Department approves of the proposed conditions and requirements, the Department will incorporate them into the operating permit.

N.J.A.C. 7:27-22.30(d)5 and (e) concern using the operating permit to explicitly define methods to determine actual emissions for reporting pursuant to N.J.A.C. 7:27-21.

N.J.A.C. 7:27-22.30(f) states that some renewal applications will be required to include modeling and risk assessment. N.J.A.C. 7:27-22.8(d) gives a list of qualifiers for such applications. For example, if the facility's potential to emit any HAP is 10 tons per year or more, a risk assessment must be included in the renewal application. For a more detailed discussion on this subject see summary of N.J.A.C. 7:27-22.8 above.

N.J.A.C. 7:27-22.30(h) explains that renewal applications are subject to all of the same public comment and EPA comment required for initial operating permit applications.

N.J.A.C. 7:27-22.30(g), (i) and (j) establish that a facility with an operating permit continues to be covered by an application shield if the renewal application is timely and administratively complete as described in N.J.A.C. 7:27-22.6. When an operating permit has expired and a facility is operating under an application shield, the conditions of the expired operating permit remain enforceable until the operating permit is issued.

N.J.A.C. 7:27-22.31 Fees

The CAA requires at 42 U.S.C. 7661a(b)(3) that each state collect fees in an amount that will adequately fund all aspects of the State's operating permit program. The operating permit program must be supported solely by fees, and no other source of funding is permitted. In assessing whether a State's fees are adequate to cover the State's operating permit program, the CAA establishes a presumption that, if the fees collected equal or exceed, in the aggregate, $25.00 per ton of pollutant emitted in the state each year, the fees will adequately cover program costs. (The CAA also requires that the fee must be adjusted each year since 1989 by the percentage increase in the Consumer Price Index (CPI) for the year.) If a state charges fees that, when aggregated, total less than $25.00 per ton of pollutant per year, EPA requires a detailed justification, explaining how the state will fund an adequate operating permit program.

In order to meet the CAA requirement that the Department charge fees in an amount sufficient to cover program costs, the proposed new rules include a two tiered fee requirement, which includes an application fee and an annual supplemental fee. The application fees are set forth at N.J.A.C. 7:27-22.31(d) and (e), and apply to applications for initial operating permits, renewals, administrative amendments, seven-day

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notices, minor modifications and significant modifications. The fees vary in proportion to the complexity of the application (and thereby to the costs incurred by the Department), so that, for example, an initial operating permit application fee would be higher than the fee for an administrative amendment.

Although the fees are graduated in proportion to the complexity of each application, the $500.00 fees are less than the actual cost to the Department of reviewing and enforcing each application. The Department is limited by the Air Pollution Control Act (ACPA) to charging no more than $500.00 per fee. Therefore, even though initial, renewal and significant modifications of the operating permit applications will cost the Department much more to review and enforce, the highest application fee proposed is only $500.00. Because the Department is limited in this way the remaining costs incurred in reviewing and enforcing preconstruction permit applications for major sources and operating permit are recovered through annual supplemental service fees, described below. This includes the cost of reviewing and enforcing preconstruction permits for major sources.

The annual supplemental service fees will cover the remaining costs of application reviews and the ongoing costs of administering and enforcing permits once they are issued. These costs include management and tracking of information pertaining to the permit and the facility, processing of periodic reports, compliance certifications, or other submittals, and performing inspections and Departmental audits. The annual supplemental fee is due each year, starting July 1, 1994, for all facilities subject to the operating permit program, even if an operating permit is not yet required for the facility under the application schedule set forth at N.J.A.C. 7:27-22.5.

In order to maximize consistency with the CAA, the Department would prefer to charge fees based on a facility's amount of emissions, rather than a fee per service. Emissions are quantified pursuant to subchapter 21 and generally correlate to the amount of resources the Department will expend in regulating the facility. In addition, an emissions fee would provide an incentive to high emitting facilities to lower emissions. However, because, as previously mentioned, the APCA does not expressly authorize fees based on emissions, the Department may not charge a fee per ton of emissions, unless an amendment to the APCA is enacted.

Therefore, in order to remedy this situation, the Department plans to seek a legislative amendment to the APCA, which would allow the Department to charge fees based on annual tons of emissions by July 1, 1994.

In order to be prepared for the enactment of such a legislative amendment, and to satisfy EPA's November 15, 1993 deadline for adoption of fees, the Department is proposing two alternative supplemental service fees. The first is authorized by the current provisions of the APCA, N.J.S.A. 26:2C-9.8(8), which authorizes the Department to charge a fee only "for any of the services it performs." This can be adopted at the close of the comment period on the present proposal. The second fee can be adopted only if the necessary legislative amendment has been implemented. Because the fees are proposed as alternatives to one another, they are both proposed at N.J.A.C. 7:27-22.31(f). They are termed "Alternative Supplemental Fee Calculation A" and "Alternative Supplemental Fee Calculation B."

Alternative Supplemental Fee Calculation A is a supplemental annual equipment fee, based on the number of pieces of equipment at a facility. Alternative Supplemental Fee Calculation B, to be adopted only if an APCA amendment is enacted to authorize it, is a supplemental emissions fee, based on the tons of air contaminant emitted each year by the facility. The proposed supplemental emissions fee is consistent with the emissions fee set forth in the CAA, that is $25.00 per ton (1989 dollars). The proposed supplemental equipment fee was also set at a level that would generate the same amount of total annual revenue that would be generated if a supplemental emissions fee of $25.00 per ton (1989 dollars) were being charged. The proposed supplemental equipment fee was also set at a level that would generate the same amount of toal annual revenue that would be generagted if a supplemental emissions fee of $25.00 per ton (1989 dollars) were being charged. If an APCA amendment is passed, the Department proposes to adopt the supplemental emissons fee rather than the supplemental equipment. If at the close of the public comment period on this proposal it appears likely that the APCA amendment will be passed prior to July 1, 1994, the Department may adopt the rest of this proposal while allowing the fee provisions to remain pending until July 1, 1994. This provides time to calculate and submit the first annual fee proposed to be due September 30, 1994.

After July 1, 1994, the owner or operator of any facility subject to subchapter 22 will be required to submit the annual supplemental fee required by the proposed rule. However, many facilities will not be required to actually obtain an operating permit until up to four years later. During the time between July 1, 1994, and the date upon which a facility actually obtains an approved operating permit, operating certificates must be maintained for all equipment within the facility, if the equipment is subject to Subchapter 8. This could result in a situation where a facility is subject to both operating permits fees under subchapter 22 and to operating certificate fees pursuant to subchapter 8. In order to avoid overlapping fees, subchapter 8 provides that supplemental operating certificate fees are not required for equipment at a facility subject to subchapter 22. However, there will be no change to the existing preconstruction permit fees required pursuant to subchapter 8. Therefore, facilities subject to subchapter 8 and subchapter 22 are subject to both preconstruction permit fees and operating permit fees.

N.J.A.C. 7:27-22.31(g), (h) and (i) set forth procedural requirements and timing of fee submittal. Application fees are to be submitted with each application for Department action. Supplemental fees are to be calculated by the owner or operator of the facility, using forms supplied by the Department. The Department has no plans at this time to bill facility owners or operators. Rather, the owners or operators are responsible for calculating and submitting the fees under the timelines established in the rule. Once calculated, the supplemental fees are to be submitted by September 30th of each year, beginning in 1994, based on information contained in the emissions report for the prior calendar year.

This section sets forth the Department's handling of all fee revenue. As stated above, the Department is required by the CAA to fully support all aspects of the operating permit program with fee revenue. This provision mandates that all fees be deposited in a dedicated fund, to be used solely for administering the operating permit program.

In developing the fees proposed in the new rule, the Department performed extensive analyses of current and projected workloads, administrative costs, and fee revenue. Details of these analyses and details of the Department's fee calculations that show how the total revenue from supplemental fees is equivalent to that from the supplemental emissions fees can be found in the "Operating Permits Workload Analysis" and "Operating Permits Fee Determination." Both reports are available for inspection during business hours at the offices of the Department and a copy may be obtained by writing to:

New Jersey Department of Environmental Protection
and Energy
Air Quality Regulation Program
Bureau of Operating Permits
CN 027
Trenton, New Jersey 08625

Because the operating permit program is new, the Department based its proposed fees on projections developed from experience with present permit programs. Accordingly, this section further provides that the Department will evaluate the actual costs of the operating permits program within two years after the approval by EPA of a full program. At that time, the actual resources expended and fees collected by the Department will be compared to the projections contained in the reports described above, and any revisions to the fee schedule may be proposed.

N.J.A.C. 7:27-22.32 Hearings and appeals

Adjudicatory hearings regarding determinations made pursuant to proposed subchapter 22 may be requested and granted in accordance with the Department's existing adjudicatory hearing provision, N.J.A.C. 7:27-8.12.

Part 70 requires that each state provide an opportunity for review in state court of final actions on operating permits. In New Jersey, that review will be in the Superior Court, Appellate Division. See R. 2:2-3 (allowing, among other things, appeals from final actions of state administrative agencies). In order to delineate when a person has the right to appeal the Appellate Division (that is, when there is final agency action), it was necessary to distinguish between those who have the right to request an adjudicatory hearing and those who do not. For those who do not have the right to request an adjudicatory hearing, the right to appeal arises when the Department takes its final permit action, for example, issues a final permit. For those who do have the right to request an adjudicatory hearing, there is no right to appeal until the hearing

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process regarding the Department's final permit action has run its course, either by the denial of the hearing request or the issuance of a final decision after a hearing.

For informational purposes, N.J.A.C. 7:27-22.32(d) includes a cross-reference to the section of the Department's penalty rules that sets forth the requirement regarding hearings for penalty assessments.

Finally, order to comply with Part 70, N.J.A.C. 7:27-22.32(e) codifies the existing ability of a person to commence a court action to compel Departmental action on a pending application when the Department has failed to comply with the legal deadlines for taking that action. The court would not order the Department to take a specific action (for example, to issue the permit), it would instead only order the Department to take some action by a date certain.

Summary of Amendments to Subchapters 1, 8 and 18

N.J.A.C. 7:27-1

N.J.A.C. 7:27-1 (subchapter 1) contains general provisions applicable to the entire air pollution control chapter, N.J.A.C. 7:27. Amendments to subchapter 1 are proposed to add key definitions, and to recodify generally applicable provisions which are currently located in other subchapters. These additions and relocations will assist the regulated public in more easily understanding the components of the Department's air pollution control program, and the interrelationships between the components.

N.J.A.C. 7:27-1.4 Definitions

N.J.A.C. 7:27-1.4 defines terms used in Chapter 27.

A definition of "preconstruction permit" is proposed in order to distinguish preconstruction permits from operating permits. The definition is the same as the existing definition of the term "permit" in N.J.A.C. 7:27-8.1, which is proposed for deletion.

A definition of "responsible official" is being proposed, in order to identify the person who must sign and certify certain documents to be submitted to the Department. The definition is consistent with that used in Part 70.

N.J.A.C. 7:27-1.31 Right to enter

This new section is proposed to clarify the Department's authority to enter and inspect any premises to determine whether the provisions of this chapter (N.J.A.C. 7:27) are being complied with. Previously, right of entry provisions were located at N.J.A.C. 7:27-8.25. This new section is substantially the same, but the proposed amendments clarify it and ensure consistency with EPA's operating permit rules at 40 CFR 70.

N.J.A.C. 7:27-1.39 Certification of information

This section, originally located at N.J.A.C. 7:27-8.24, sets forth the requirements for the certification that must accompany any air pollution application, report or document to the Department. Because these certification requirements apply to information submitted to the Department under many different subchapters, the section is proposed for recodification to subchapter 1, where it will apply to the entirety of N.J.A.C. 7:27, except for emission statements which have a similar, but more specific, certification in N.J.A.C. 7:27-21.

Concerning the persons who may sign the second level certification, the amendments move this description into the definition of "responsible official." The definition of a responsible official contains the basic substance of the former rule provision describing the required signatory, by a ranking official with some changes which allow more flexibility in who may sign the second level certification. Certification by a duly authorized representative of a ranking official would be allowed. Also, a person with policy or decision making functions similar to a ranking official would be able to certify. Both of these flexibilities are consistent with Federal requirements for large facilities.

Also, the proposed rule would change the certification procedures somewhat to be the same as the certification procedures of N.J.A.C. 7:27-21, Emission Statements.

The existing two part certification would become mandatory in all cases, except where the "knowledgeable" person certifying the first level is the same as the "responsible" company official for the second level certification, in which case only the first level certification is needed. In the current certification procedures, the second level certification is only required in certain cases. Also, the first level certification would change from "highest ranking individual with direct knowledge and overall responsibility for the information" to the "individual or individuals (including any consultants) with direct knowledge of and responsibility for the information." This resolves the confusion with the existing certification which occurs when the person(s) with "direct knowledge" of the information is not the person with "overall responsibility" for the information. The rule also provides for certification by the persons with direct knowledge of the information, which better assures the accountability of the information and is compatible with the second level certification by the responsible official. By having the person with direct knowledge provide the first level certifications, the responsible official is better able to certify "based on inquiry of those individuals immediately responsible for obtaining the information."

N.J.A.C. 7:27-8

N.J.A.C. 7:27-8 (subchapter 8) contains the Department's existing rules regarding preconstruction permit and operating certificates. The proposed amendments will clarify subchapter 8 and make it consistent with proposed subchapter 22. The following is a summary of the significant changes proposed to subchapter 8, followed by a detailed discussion of all of the proposed amendments.

A. Flexibility

The proposed amendments at N.J.A.C. 7:27-8.15 add a process originating in the EPA operating permit rules called a seven-day-notice change. Many operational changes which do not increase emissions can be made through a seven-day-notice change, without a preconstruction permit. This requires that the owner or operator notify the Department seven days prior to making the change. After filing the notice, the owner or operator may proceed "at risk" after waiting seven days. The types of changes which may be made as seven-day-notice changes were formerly processed as amendments pursuant to N.J.A.C. 7:27-8.3(c).

B. Applicability

Amendments are proposed at N.J.A.C. 7:27-8.2 to exempt two new categories of equipment from subchapter 8: woodworking equipment which vents indoors, and control apparatus voluntarily installed on equipment which would not otherwise require a permit. The proposed amendments add a requirement that any source operation which emits hazardous air pollutants over certain defined de minimis levels must have a permit, and clarify that newspaper printing presses require permits. The amendments require that permit applications for newspaper printing presses be submitted by September 1, 1994.

The amendments require a permit for all paint spraying equipment used for manufacturing. Large spray painting equipment was previously subject to the permit requirement pursuant to other provisions in N.J.A.C. 7:27-8.2(a). This amendment will bring small paint spray operations under the purview of the rule.

The proposed amendments add burners of over 10 million BTUs per hour to the list of equipment which constitutes a "substantial component." This brings the replacement of very large burners into the category of an "alteration," which means that the replacement burners must meet the state of the art requirements for new equipment set forth at N.J.A.C. 7:27-8.4. This is consistent with the Department's proposed NO_x control rules at N.J.A.C. 7:27-19 (see 25 N.J.R. 631(a)).

C. Fees

The amendments propose the deletion of operating certificate fees for facilities subject to operating permit fees, as operating certificates are no longer needed for equipment at such facilities.

The proposed amendments to N.J.A.C. 7:27-8.11 delete the current fee for address changes and other similar changes which require no technical review and little paperwork.

The amendments also change the method of calculating the number of pieces of equipment which are subject to fees. Currently, an applicant pays one fee per piece of equipment. The proposed provision allows different pieces of equipment to be counted as one piece, if all the equipment uses the same process and raw materials. For example, two of the same type of printing presses using the same kinds of ink can be counted as one piece of equipment subject to a single fee. This change applies only to application fees for category II applications.

The definition of "category I" is also amended to expand the class of permit applications which are considered "category I" applications. Category I applications are those which are simpler and more easily reviewed, and thus have a quicker review and lower fee.

D. Application Content

Amendments to N.J.A.C. 7:27-8.4 are proposed which allow applicants to list fewer air contaminants on permit applications. The proposed new provision, at N.J.A.C. 7:27-8.4(m), specifies that any air contaminant

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emitted below defined de minimis emission levels need not be included on the application unless the contaminant may result in offsite odors.

E. Certification of Information

The certification requirements for information submitted to the air pollution control program are proposed for amendment (see discussion above in summary of changes to subchapter 1). These amendments require certification by a "responsible official." This term is similar to "ranking official" the Department's existing requirement concerning the persons which must certify the second level certification, pursuant to existing N.J.A.C. 7:27-8.24(d), but provides more flexibility for companies with facilities at multiple locations. "Responsible official" is also consistent with EPA's operating permit rule and with the Department's Emission Statement Rule. As discussed above in the discussion of N.J.A.C. 7:27-1.39, Certification of Information, the certification procedures would be changed to be the same as the certification procedures of N.J.A.C. 7:27-21, Emission Statements.

Discussion of Individual Proposed Changes:

Throughout subchapter 8 and subchapter 18, Emission Offsets, the term "permit" is proposed to be changed to "preconstruction permit." Prior to the recent adoption of the Department's Pollution Prevention Rules and to the current proposal, the Department issued only one type of air pollution control permit. However, now a facility can also obtain a second type of air permit called a facility-wide permit issued pursuant to N.J.S.A. 13:1D-35 et seq., the New Jersey Pollution Prevention Act. The proposed new subchapter 22 will create a third new type of air pollution control permit, called an operating permit, which will regulate major sources of air contaminants. It is necessary to amend subchapter 8 to distinguish between these types of permits.

N.J.A.C. 7:27-8.1 Definitions

A definition of "administrative amendment" is proposed. The proposed administrative amendment process is quite similar to the current process for amendments now found in subchapter 8. However, the name has been changed to administrative amendment to be consistent with subchapter 22 and EPA's operating permit rules. In addition, the provisions regulating the process have been reorganized so that the definition now refers to the relevant section of the rule.

The proposal adds definitions of "applicable Federal requirement," "applicable requirement," and "applicable State requirement." These are terms used in subchapter 22 to refer to the various Federal and State requirements and standards applicable to a facility or source operation. They are included here because, in the proposed new section providing for seven-day-notice changes, the permittee is required to provide with the seven-day-notice a statement that the equipment being modified will comply with "all applicable requirements."

The substance of the definition of "alteration" is being moved from the definitions section and placed into a new section, N.J.A.C. 7:27-8.16, Alterations. This reorganization will make these important regulatory provisions easier to find and use. A similar reorganization of the provisions governing amendments is also proposed. The substantive provisions regulating amendments have been relocated to their own section of the rule at N.J.A.C. 7:27-8.14.

A definition of "architectural coating" is proposed in order to exempt the architectural coating of buildings, bridges, houses, signs, curbs and pavements from the proposed new permitting requirements for paint spray operations found at N.J.A.C. 7:27-8.2(a)1. Such operations should be exempt from permitting requirements because they constitute single events that are not routinely conducted. VOC emissions from such operations are controlled by specifying volatile content for these coatings in N.J.A.C. 7:27-23.

"Amendment" is being deleted from the rule and replaced by "administrative amendment." This is consistent with the term used in subchapter 22.

The definition of "banking" is being revised to conform with the definition in subchapter 18, governing emission offsets.

The definition of a "category I" permit application has been expanded to include more types of equipment. A category I application includes equipment which is relatively simple to review. The Department has developed simplified review procedures for certain types of equipment and is therefore shifting these into category I. The additional sources added to category I include: other small surface coating operations besides paint spraying, controlled enclosed sandblasting operations, plastics grinding machines, and certain open top parts washing and degreasing machines using non-HAP compounds.

"Clean Air Act" and "Department" are proposed because they are important to many sections of the chapter and were never before defined.

The proposal adds a definition of "freeboard chiller" because, in order for an open top surface cleaner to qualify for processing as a category I application, it must be equipped with a freeboard chiller.

"Delivery vessel" is added to the rule because the term is used in the definition of "stationary storage tank." The definition of "stationary storage tank" will be discussed below.

"Graphic arts" is proposed to be added to clarify the Department's longstanding practice of considering graphic arts operations as subject to permitting requirements. This is important because N.J.A.C. 7:27-8.2(a)2 requires an operating certificate for graphic arts operations if the use of cleaning or coating material exceeds one half gallon in any one hour. This proposed amendment will clarify that graphic arts operations meeting this criterion are subject to subchapter 8. Departmental policy has always been to consider graphic arts as a coating operations and to require such operation to obtain a permit. Defining and including graphic arts in subchapter 8 will remove any doubt that this is the case.

"Hazardous air pollutant" or "HAP" is defined identically to subchapter 22, and refers to the Federal list of hazardous air pollutants. This Federal list was expanded by the CAA in 1990 from seven to 189 compounds.

Definitions of "operating permit" and "preconstruction permit" are both added to replace the definition of "permit."

"Person" is being revised to be consistent with definitions of person in other subchapters.

A definition of "plastics grinding equipment" is proposed because this type of equipment is being added to the class of category I applications.

A definition of "potable water" is proposed to clarify the Department's longstanding interpretation of the term. It is used at N.J.A.C. 7:27-8.2(b)3, to explain the applicability of subchapter 8. This term generally refers to water used for drinking or cooking.

The proposed definition of "seven-day-notice change" refers the reader to the section of the rule, N.J.A.C. 7:27-8.15, which provides for, and explains the procedure for, these types of changes.

The proposed definition of "stationary storage tank" is identical to the definition of this term presently found in subchapter 16. This is because a station delivery vessel used as a storage tank poses the same environmental dangers and can use the same pollution controls as other storage tanks. Because subchapter 8 requires permits for certain storage tanks, there has been some uncertainty over permit requirements when a delivery vessel is kept at a facility for a long period and is used as a storage tank. The proposed definition will clarify that any delivery vessel used as a storage tank for 30 or more days constitutes a stationary storage tank and its emissions will be controlled as is required for stationary storage tanks.

The definition of "substantial component" is being expanded to include certain large burners, used on boilers. These burners are the major source of emissions from boilers, and are essential to the functioning of the boiler. The inclusion of these burners in the definition of substantial component will close a loophole in the current regulatory scheme, by bringing the replacement of very large burners into the category of an "alteration," which means that the replacement burners must meet the state of the art requirements for new equipment set forth at N.J.A.C. 7:27-8.4. This is consistent with the Department's proposed NO_x control rules at N.J.A.C. 7:27-19.

The proposal adds a definition of "surface coating operation" in order to clarify the applicability of subchapter 8.

N.J.A.C. 7:27-8.2 Applicability

N.J.A.C. 7:27-8.2, Applicability, sets forth the equipment which requires a preconstruction permit and an operating certificate. The proposed amendments to N.J.A.C. 7:27-8.2(a)1 delete the requirement for permits and certificates for control apparatus which is attached to equipment which does not itself require a permit. The Department is proposing this change in order to remove a disincentive to voluntary installation of control apparatus. Presently, if a piece of equipment does not require a permit, the installation of control apparatus will make the equipment subject to permitting requirements. This may function to discourage installation or use of control apparatus on equipment not otherwise subject to permitting requirements. To avoid this, and to ease the regulatory burden on the regulated community, the proposal deletes the requirement to obtain a permit for control apparatus, if the equipment served by the apparatus does not itself require a permit.

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A new provision is proposed at N.J.A.C. 7:27-8.2(a)1 to require permits for any equipment used in a commercial paint spray operation except for equipment used in architectural coating operations. The larger of these paint spray operations were previously subject to permit requirements because of the control apparatus attached to them, or under the permit requirements for equipment introducing more than 50 pounds of raw material into a process per hour, or for surface coating operations using more than one half gallon an hour of coating. This new provision will expand coverage of the rule to all commercial paint spray operations, regardless of size, to ensure that they are equipped with paint filters. This is necessary because the conduct of such operations without filters results in paint carryover to nearby, off-site locations. The proposed permit requirement for paint spray operations contains an exemption for architectural coatings. This exemption allows the painting of buildings, bridges, the interior and exterior of houses, and items such as signs, curbs, and pavements, without the necessity of a permit.

N.J.A.C. 7:27-8.2(a)15 is amended to clarify the types of waste and water treatment equipment which are subject to the requirements for preconstruction permits. The amendment does not change the meaning of the rule, it merely reorganizes and clarifies it.

A clarification is added to N.J.A.C. 7:27-8.2(a)16 to indicate that transfer stations, recycling facilities, and municipal solid waste composting facilities are classified as solid waste facilities.

An amendment is proposed to N.J.A.C. 7:27-8.2(a)17 to specify, rather than refer to, an exception rate found in another subchapter. The current rule refers the reader to N.J.A.C. 7:27-17 to find the rate. The proposed amendment will specify the rate (0.1 pounds per hour of 45.4 grams per hour) in the text of the rule.

A new provision is proposed at N.J.A.C. 7:27-8.2(a)18 to require permits for any equipment required to have a control device under any subchapter. Again, this provision is necessary because many small, but high emitting, pieces of equipment are presently permitted only because the control apparatus attached to them is subject to permitting requirements. The proposed new provision exempting those control apparatus from permitting could be interpreted to exempt not only the control apparatus, but the equipment it serves. This proposed provision clarifies that a permit is still required for the equipment, and that any new or altered control apparatus required by any other subchapter also requires a permit to ensure that it will comply with advances in the art of air pollution control.

A provision is added at N.J.A.C. 7:27-8.2(a)19 requiring a permit for control apparatus if the control apparatus serves equipment which is required to have a permit. This provision was added to ensure that the deletion of certain control apparatus from permit requirements (see discussion of N.J.A.C. 7:27-8.2(a)1 above) does not act to exempt any control apparatus which is attached to equipment already requiring a permit. The goal of the proposed exemption of control apparatus at N.J.A.C. 7:27-8.2(a)1 is to remove a disincentive to voluntary installation of controls on equipment which would otherwise not require a permit. If a permit is already required for a piece of equipment, the additional burden of permitting any control apparatus attached to it is not a disincentive to installing the control apparatus.

A provision is added at N.J.A.C. 7:27-8.2(a)20 clarifying the fact that permits are required for newspaper printing presses. This has been a point of confusion in the past. Although virtually all of the newspaper printing presses in the State are subject to subchapter 8 because they are considered coating operations which use more than one half gallon per hour of coating pursuant to N.J.A.C. 7:27-8.2(a)2, EPA has in the past published guidance stating that newspaper printing presses emitted no air contaminants. Because subchapter 8 applies only to equipment which emits air contaminants, some persons interpreted this guidance to exempt newspaper printing presses from subchapter 8. EPA has since determined that air contaminants are in fact emitted from newspaper printing presses. Therefore, the Department is amending this provision to clarify that newspaper printing presses are subject to subchapter 8. The proposal requires that, for existing presses, permit applications must be submitted by September 1, 1994.

N.J.A.C. 7:27-8.2(a)21 is proposed to require that any equipment emitting significant quanties of toxic pollutants are subjected to the permitting requirement and thereby required to control those emissions at least to the degree possible through advances in the art of the control technology.

N.J.A.C. 7:27-8.2(b) sets forth equipment which, notwithstanding N.J.A.C. 7:27-8.2(a), does not require a permit. This subsection is proposed for expansion to include equipment used for woodworking, if the woodworking equipment vents indoors. This applies to small operations that use self-contained vacuum cleaner like controls for sawdust. Such operations are usually sporadic and result in minimal emission to the outdoor atmosphere. Large industrial woodworking operations would not be exempted under this provision since the types of control apparatus used on these operations vent outdoors. Aeration basins, lagoons and settling basins at publicly owned or domestic treatment works as well as potable water treatment equipment (except air stripping equipment with a 100,000 gallon or more per day capacity) would continue to be exempt from preconstruction permit requirements, as they are in the current rule. A new provision at N.J.A.C. 7:27-8.2(b)6 continues the present exemption of intake air filter from permitting requirements, even if the air intake filter is attached to equipment requiring a permit.

N.J.A.C. 7:27-8.3 General provisions

The proposal includes amendments to N.J.A.C. 7:27-8.3(c). This subsection previously listed changes that may be processed as amendments. Most of these changes have been relocated to the section of the proposed rule governing administrative amendments at N.J.A.C. 7:27-8.14. Some, however, have been relocated to the section governing seven-day-notice changes at N.J.A.C. 7:27-8.15. These sections are discussed in more detail below. A new provision is also added at N.J.A.C. 7:27-8.3(c) which requires changes to be made to equipment or control apparatus through an administrative amendment, seven-day-notice change, or in alteration in accordance with the procedures set forth at N.J.A.C. 7:27-8.14, 8.15 or 8.16, respectively.

N.J.A.C. 7:27-8.3(e)1 and 2 are combined and streamlined without changing the meaning of the subsection.

The substance of the current N.J.A.C. 7:27-8.3(k), which concerns decreases in hours of operation or allowable emissions rates, is relocated. The provision is now reflected in N.J.A.C. 7:27-8.4(b), Administrative amendments, and in N.J.A.C. 7:27-8.15(c)8, Seven-day-notice change. If the decrease in allowable emission rate does not involve either a physical or an operational change, then it may be processed as an administrative amendment. However, if the decrease in allowable emission rate involves an operational change, it must be processed as a seven-day-notice change. If the decrease in allowable emissions entails a physical change, neither of these processes may be used.

Proposed N.J.A.C. 7:27-8.3(k) contains provisions to allow an environmental improvement pilot test of air pollution control equipment or other environmental clean-up equipment.

A new provision is added at N.J.A.C. 7:27-8.3(l)1 which exempts equipment at facilities, covered by an operating permit pursuant to subchapter 22, from the requirement to obtain an operating certificate. In addition, proposed N.J.A.C. 7:27-8.3(l)2 exempts facilities which have a facility-wide permit from being required to obtain an operating certificate. (N.J.A.C. 7:27-8.17, Exemption of facilities subject to the Pollution Prevention Act, relocated in the proposal from N.J.A.C. 7:27-27 in current subchapter 8, contains the requirements for exemption.) These permits provide a sufficient amount of control over the facilities to obviate the need for a separate operating certificate.

N.J.A.C. 7:27-8.3(m) provides an affirmative defense to certain penalties for air pollution violations. The affirmative defense is available for violations caused by equipment malfunction, equipment startup and shutdown, and necessary equipment maintenance, provided that certain requirements are met, such as proper operation of equipment and prompt notice to the Department. The proposed provision also includes an affirmative defense for violations caused by emergencies, which is consistent with Part 70. Although Part 70 does not require that the emergency affirmative defense be extended to facilities without operating permits, the Department is including the defense here to be equitable and reasonable. A corresponding provision is proposed in subchapter 22 at N.J.A.C. 7:27-22.16(l).

N.J.A.C. 7:27-8.4 Applications for preconstruction permits and certificate

This section is amended to add a provision, at N.J.A.C. 7:27-8.4(l), for Department authorization of "environmental improvement pilot tests" of air pollution control equipment or other environmental cleanup equipment. This allows the testing of sites to determine levels of contamination. This authorization is quicker and less expensive than the review of a standard preconstruction permit application. The provision will ease the regulatory burden on persons who are performing environmentally beneficial testing of pollution control and cleanup activities.

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The proposed amendments add N.J.A.C. 7:27-8.4(m), which requires that all air contaminants emitted by a source operation be listed on a permit application, if the air contaminant is emitted in greater than de minimis amounts, or in an amount which may be detectable offsite by smell. This reduces the regulatory burden on the public by reducing the number of air contaminants which must be measured and reported on applications.

A new subsection (n) is added to N.J.A.C. 7:27-8.4, which clarifies that, for a source operation which emits no air contaminant which must be listed on a permit application pursuant to the proposal provisions of N.J.A.C. 7:27-8.4(m), a statement to that effect must be included in the application, along with a statement that there will be no contaminants emitted in an amount which may be detectable by the sense of smell at the facility's property boundary. If there may be an air contaminant above these amounts, the air contaminants must be listed in the application.

N.J.A.C. 7:27-8.6 Denials

A provision is added, at N.J.A.C. 7:27-8.6(e), requiring that all paint spray operations have, at a minimum, particulate control apparatus, in order to be eligible for a preconstruction permit. As discussed above (see summary of N.J.A.C. 7:27-8.2(a), Applicability), these operations were previously subject to the rule. This proposed new provision clarifies the minimum standards for issuing a permit for these operations. At a distance, spray operations without the minimum control may not be noticeable, but on adjacent properties, uncontrolled spraying results in unintentional, off-site applications.

N.J.A.C. 7:27-8.7 Approvals

General provisions at N.J.A.C. 7:27-8.7(a) and (b) are amended to clarify that these provisions apply only to equipment which is subject to the requirement for a preconstruction permit or operating certificate.

N.J.A.C. 7:27-8.8 Conditions of approval

This section proposes to clarify that the term "permit" applies only to preconstruction permits and not to facility wide permits and operating permits.

N.J.A.C. 7:27-8.9 Reporting requirments

The proposed amendments clarify at N.J.A.C. 7:27-8.9(a) that a permittee must provide the Department with information upon request, even if the information is not specifically required by the permit. The amendments also add to N.J.A.C. 7:27-8.9(c) the requirement that a seven-day-notice be certified. Finally, N.J.A.C. 7:27-8.9(e) clarifies that reporting requirements apply to seven-day notice changes as well as administrative amendments.

N.J.A.C. 7:27-8.11 Service fees

N.J.A.C. 7:27-8.11 contains the base fee schedule and the supplementary fee schedule currently used to determine permit fees. Several amendments are proposed to this section. N.J.A.C. 7:27-8.11(a) adds seven-day-notice changes and environmental improvement pilot tests to the list of items for which fees are required. A new subsection is proposed at N.J.A.C. 7:27-8.11(e) which provides that certain operating certificate fees need not be paid for equipment which is covered by operating permit fees pursuant to subchapter 22.

An explanatory provision is proposed at N.J.A.C. 7:27-8.11(f) to clarify that an application for a preconstruction permit must include two fees: one each for the precosntruction permit and the operating certificate.

The base fee schedule is amended at item 3a to delete the fee for address changes and other similar changes which require no technical review and little paperwork. The remaining fees for amendments are unchanged. However, because several changes which were previously amendments have now been reclassified as seven-day-notice changes, the fees for those changes are found at item 3c under the heading for seven-day-notice changes. The ultimate effect of this provision is that the fee for any given change is unaffected by the proposal, except for minor corrections such as name and address changes, for which the fee has been deleted.

The method of calculating the number of pieces of equipment which are subject to fees for category II applications is also changed. Currently, an applicant pays one fee per piece of equipment. The proposed provision allows different pieces of equipment to be counted as one piece, if these pieces of equipment use the same process and raw materials. For example, two of the same type of printing presses using the same kind of ink can be counted as one piece of equipment subject to a single fee, if both are listed on one permit application. This results in a substantially lower fee than if they were treated as separate pieces of equipment, which is justified by the amount of resources the Department is required to expend reviewing the "joint" application.

Item 6 in the base fee schedule is a newly proposed item to provide for a fee of $250.00 for an application for an environmental improvement pilot test. A more detailed discussion of the new procedure for approval of an environmental improvement pilot test is found at the summary of N.J.A.C. 7:27-8.4(l).

N.J.A.C. 7:27-8.14 Administrative amendments

This proposed new section contains the procedures for administrative amendments, and the list of changes which may be processed through an administrative amendment. The current rule includes a list of changes termed "amendments." The fee schedule then splits amendments into two categories, one of which includes simple changes requiring no technical review and a lower fee. The other requires some technical evaluation and a higher fee. The new rule separates these two categories, placing the more complex changes into the seven-day-notice change section, discussed below. The simpler changes are located in this section, renamed administrative amendments, and processed according to this section. The fees remain the same as in the current rule, with the exception of several minor administrative amendments, for which the fee is deleted.

In order to be consistent with the process for administrative amendments in subchapter 22 and EPA's operating permit rules, the time is changed within which a permittee must notify the Department of an administrative amendment, if the facility is covered by an operating permit. Where the current rules allow a permittee to notify the Department up to 120 days after making a change which constitutes an amendment, the new rule requires that, for operating permit facilities, the Department must receive notice of the change before the change is implemented. For those sources not subject to the requirement for an operating permit, the timing of an administrative amendment remains the same—the Department must be notified within 120 days after the change is made. Although this is more restrictive for operating permit facilities, the Department believes it is justified because the requirement is not onerous, and because it is important for subchapter 8 to be consistent with the provisions for administrative amendments in subchapter 22.

N.J.A.C. 7:27-8.15 Seven-day-notice changes

This new section is proposed to provide consistency with subchapter 22. The section creates a process for making changes which requires seven-days prior notice to the Department. This section includes changes which were formerly found in the more complex of the two categories of amendments. For these changes, the only aspect of the process which is affected by the proposal is the timing of notice to the Department. Where, formerly, these changes could be made with notice to the Department any time within 120 days after the change, the new rule requires that the Department receive seven-days prior notice. Again, this slightly more restrictive provision is necessary to provide consistency with subchapter 22.

The new rule also adds an important new type of seven-day notice change, termed an "alternative operating scenario." The alternative operating scenario originated in subchapter 22. In subchapter 22, an alternative operating scenario can be pre-approved as part of a permit, or can under certain conditions be approved through the seven-day notice provisions. This new type of change provides added flexibility to facilities which must change processes to accommodate their business needs.

N.J.A.C. 7:27-8.16 Alterations

This new section is proposed to house the substantive provisions which were formerly located within the definition of "alteration." The new rule contains the same class of changes which constitute an alteration in the current rule, with one exception. The provision for reconfiguration is relocated to the "alternative operating scenario" portion of seven-day-notice changes. See the summary of the seven-day-notice section for a discussion of this change. For facilities which are not subject to subchapter 22, the new provision does not change the process for obtaining approval of an alteration. However, for facilities covered by an operating permit pursuant to subchapter 22, an alteration will be processed in the same manner as, and simultaneously with, the change made to the operating permit. Under subchapter 22, some of the changes classified as alterations would be processed as minor modifications, and others as significant modifications.

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N.J.A.C. 7:27-8.17 Exemption for facilities subject to the Pollution Prevention Act

As part of the Department's effort to improve the overall effectiveness of the preconstruction permit program and to encourage facility-wide permitting, under the New Jersey Pollution Prevention Act (N.J.S.A. 13:1D-35), subchapter 8 revisions were recently adopted which would allow certain equipment changes to be made as "amendments," rather than "alterations." See 24 N.J.R. 4323(a) (proposal) and the notice of adoption published elsewhere in this issue of the New Jersey Register. To be consistent with the requirements of Part 70, most of the changes listed in current subchapter 8 as amendments are now proposed as "seven-day-notice changes" in N.J.A.C. 7:27-8.15. This includes the reporting requirements for changes made under the pollution prevention exemption. The changes would be reported seven-days before making the change, rather than 120 days after the occurrence of the alteration or change. This section as previously located at N.J.A.C. 7:27-8.27.

N.J.A.C. 7:27-8.24 Certification of information

As discussed above in the summary of the changes to subchapter 1, this section is being moved to subchapter 1, General provisions, and amended slightly. The certification provisions will be recodified as N.J.A.C. 7:27-1.39.

N.J.A.C. 7:27-8.25 Inspections

This section is proposed for deletion, and the substance of the section relocated to subchapter 1. See the summary of changes to subchapter 1 above for a discussion of this change.

Appendix I

An Appendix I containing four tables is proposed. Table A lists hazardous air pollutants (HAPs) which trigger the requirement for a permit if emissions are greater than 20 pounds per year, pursuant to N.J.A.C. 7:27-8.2(a)21vii. Table B lists HAPs which trigger the requirement for a permit if emissions are greater than 200 pounds per year, pursuant to N.J.A.C. 7:27-8.2(a)21viii. Tables C and D list the de minimis levels for HAPs and other air contaminants. If equipment has the potential to emit a contaminant at or above the de minimis level, the contaminant must be listed on the permit application.

Environmental Impact

Subchapters 1 and 18

The amendments to subchapters 1 and 18 are proposed mostly to maintain consistency with proposed subchapter 22 and the amendments to subchapter 8. There are substantive proposed amendments to the certification procedures in subchapter 1 that will have an indirect but positive environmental impact by ensuring that the appropriate persons at facilities certify information provided to the Department.

Subchapter 8

The environmental impact of the proposed amendments to subchapter 8 will also be positive and largely indirect. Most of the proposed amendments do not alter the substance of the current regulatory scheme. Rather, they streamline the administration of the permit process, and in many cases, ease the burdens on the regulated community. By reducing some fees, and reducing some permit requirements, more resources will be available to the Department and the regulated community for prevention and control of significant air contaminant emissions.

The proposed amendment to include large burners in the definition of a "substantial component" will result in direct environmental benefits, because lower emissions will result from the improved burners, by the incorporation of advances in the art of air pollution control as a preconstruction permit requirement.

The Department proposes to remove from subchapter 8 the permit requirement for control apparatus that is attached to sources not otherwise requiring permits. This should result in improved air quality by removing a disincentive to voluntary installation of control apparatus.

The proposed amendments to require permits for newspaper printing presses, for all paint spray operations, and for all equipment emitting certain levels of toxics will have beneficial environmental impacts. These operations will be subject to permit review which will improve air quality. For example, the permit review process will help ensure that paint spraying is done in booths equipped with filters that limit the emissions of particulates.

Subchapter 22

The Department expects the environmental impacts of subchapter 22 to be positive and substantial. Although most of subchapter 22 does not create new emissions limits or standards, it will significantly improve compliance with existing standards. First, subchapter 22 will require a permit for many facilities or source operations which have heretofore been unpermitted. This will better inform owners and operators of these facilities of the air pollution control requirements that apply to their equipment. Second, subchapter 22 will also require periodic monitoring, recordkeeping and reporting of emissions related information. This will aid facilities and the Department in assessing and improving compliance with existing regulations and standards. Third, public participation will provide an opportunity for the public to identify and recommend changes to operations or permit conditions that could result in further environmental improvements. Finally, locating all requirements applicable to a facility in a single permit will assist the Department's inspectors and enforcement staff in identifying and addressing noncompliance. These aspects of subchapter 22 will indirectly in a substantial reduction in air contaminant emissions.

Subchapter 22 will also have a beneficial environmental impact in that it will require facilities emitting certain types of hazardous air pollutants (HAP's) to perform an assessment of these emissions on public health. These assessments will be part of the draft operating permit which will be subject to public comment. Because of the public interest in HAP emissions, facilities are expected to minimize HAP emissions, either prior to applying for an operating permit, or as part of a compliance plan submitted with the application. This will avoid adverse public reaction to high risk situations. The resulting reduction in HAP emissions will be environmentally beneficial to the citizens of the State.

Subchapter 22 also includes incentives for early reduction of HAP emissions. These incentives will promote pollution prevention technologies to reduce activities and raw materials which generate HAP emissions.

The operating permit will serve as the vehicle for the Department to administer significant parts of the Federal air toxics program, the new acid rain program and required reductions in nonattainment air contaminant emissions. Consequently, the operating permit program will assist in obtaining and verifying these reductions.

Social Impact

Subchapters 1 and 18

The proposed amendments to subchapter 1 will have a positive social impact by aiding the public to understand the Department's air pollution control program by reorganizing diverse parts of the administrative code that apply to more than one subchapter and placing them in subchapter 1, General provisions. Also, the revisions to the document certification procedures in subchapter 1 will encourage compliance by having the appropriate knowledgeable and responsible persons certify the truth and accuracy of those documents. The proposed amendments to 18 are only to define "permit" as "preconstruction permit" and will not have any direct or indirect social impact.

Subchapter 8

The main social impact of the proposed amendments to subchapter 8 will be to streamline the preconstruction permit process. The proposed amendments will reduce Department permit review time, without compromising the effectiveness of the regulatory program. This will be accomplished through the use of an improved permitting processes and the focusing of Department and private resources on the more significant sources of air pollution. This will free some of the Department's limited resources for more effective air pollution regulation. In addition, the improved air quality resulting from the rule amendments will have the positive social impacts of better health and of a reduction in all the costs associated with air pollution.

Subchapter 22

The Department expects the proposed new subchapter 22 to have a positive social impact. While subchapter 22 does not itself impose any new substantive requirements, it does provide a comprehensive vehicle to regulate approximately 25,000 stacks at 900 facilities in New Jersey. Currently, each piece of new or altered equipment requires a separate operating certificate. In addition, the emission limits, monitoring, recordkeeping and reporting requirements to which a facility is subject are not all contained in each permit. Rather, these requirements are scattered among numerous provisions of Department regulations.

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Subchapter 22 will consolidate all equipment at a facility into one operating permit, which will include all State and Federal requirements applicable to the particular facility. This will make it easier for the regulated public to understand and comply with the entire air pollution control program. Furthermore, it will provide the information necessary for the Department to accurately assess compliance or noncompliance at a facility.

Another important benefit of the proposed new subchapter 22 is that the operating permit program will ensure that states have the resources necessary to develop and administer the air pollution control program for major stationary sources effectively. In particular, the permit fee provisions of Title V of the CAA require the State to fund the operating permit program from fees. The proposed rules would place the costs of the operating permit program on the major facilities subject to its requirements, consistent with the "polluter pays" principle and Federal requirements.

Fees may be based on actual emission levels, which would create an incentive for facilities to reduce emissions. The incentive may encourage a facility to engage in pollution prevention activities that create a positive environmental benefit and result in an economic benefit to the facility. (See summary of N.J.A.C. 7:27-22.31, Fees, above.)

The proposed new rules will also increase public involvement in the air pollution control permitting process. Each draft operating permit and significant modification will be subject to public comment and the possibility of a public hearing prior to its finalization. This public participation will promote accountability of Department decisions and generally result in better and more democratic decision-making. In addition, the prospect of public scrutiny of a company's air pollution control practices will encourage voluntary compliance.

The Department expects that these rules will also be a vehicle for innovative approaches to air pollution control, such as emissions trading programs. In order to comply with air pollution control regulations, a company will often invest in new equipment. Because of advancing technology, the new equipment will sometimes control air emissions to a level subtantially below that required by law. The operating permit will provide the facility with a readily available mechanism to record and track facility-wide emissions and control requirements. This recording and tracking will lay the foundation for pursuing market-based trading programs. This aspect of the operating permit will be the first step in establishing the currency necessary for a market-based emission trading program. Under a trading program, the company can consider the extra reduction in emissions as a "credit" which it can then sell to another company, or place in a Department administered "bank." Such provisions encourage a company to install the best available control technology or develop new and better control technology, thereby reducing total pollutant loadings.

The operating permit will also be helpful in future efforts to encourage facility-wide permitting and "multi-media" pollution reduction. The proposed new operating permit program takes a major step toward a comprehensive understanding of a facility's total air pollution potential by gathering all information regarding a facility's air contaminant emitting sources and activities into one document.

Recognizing the need to streamline the processing of minor or routine operational changes, the Department is proposing to introduce several opportunities for operational flexibility. These should allow facilities to meet their environmental obligations in a more efficient manner.

Economic Impact

The proposed new rules and rule amendments will have a substantial economic impact. In general, they will cause increased expenses for major air pollution sources, and a slight decrease in expenses for minor sources of air pollution.

The major economic impacts of subchapter 22 will stem from the fact that Title V of the CAA requires each state to collect sufficient permit fees to cover the costs of the operating permit program and that subchapter 22 will require approximately 900 facilities in New Jersey to obtain operating permits.

In sections other than Title V, the CAA requires the installation of air pollution controls. In the future, enhanced monitoring will be required by EPA, resulting in increased costs associated with testing, monitoring and recordkeeping, and reporting. Economic impacts from these requirements will not be discussed here, but will be included in other State or Federal rule proposals. The economic impacts discussion related to this proposal will be limited to those costs directly associated with the operating permit and operating application preparation.

The cost of complying with MACT and GACT requirements will be a function of other, yet to be adopted, State and Federal rules. For existing sources of HAPs which become subject to Federal MACT and GACT rules, the costs of those requirements will be addressed in EPA's preambles to those rules. For existing sources of HAPs for which EPA fails to timely adopt MACT standards, the State must determine MACT on a case-by-case basis. The cost of such case-by-case MACT cannot be projected because of the large number of source categories, about 150, for which EPA must develop MACT standards and because it is unknown for which categories, if any, EPA will miss its deadline by more than 18 months. For new and altered sources of HAP emissions, the requirement for MACT or GACT will be addressed with existing State preconstruction permit requirements that new and altered equipment incorporate advances in the art of air pollution control. Therefore, no additional costs for MACT and GACT will result from these rules, except the administrative costs of permitting, which are addressed elsewhere.

To minimize the economic impact to facilities subject to these rules, the Department has incorporated several cost saving procedures. These include: combining the subchapter 8 and subchapter 22 application and review processes for permit modifications; providing a more flexible and expeditious permitting mechanisms by which applicants may efficiently change their air pollution permits to reflect changes in their manufacturing processes; upgrading the Department's application forms to be more user friendly; and instituting a Small Business Assistance Program to assist small businesses in understanding and complying with air pollution control rules. It is difficult to estimate the economic benefits of these efforts to the regulated community, but the Department believes that they are substantial.

Subchapters 1 and 18

The proposed amendments to subsection 1 and 18 will have a slight economic benefit because they will help streamline the permit process.

Subchapter 8

Because facilities subject to subchapter 22 will no longer require operating certificates, their costs in relation to subchapter 8 certificates to operate will decrease as of July 1, 1994. However, this decrease will be offset by the costs associated with complying with subchapter 22. (See the discussion below of the economic impact of subchapter 22.)

Overall, the proposed amendments to subchapter 8 will have a relatively small, but beneficial, economic impact. For equipment which will be exempted under the proposed amendments (such as small woodworking operations and the voluntary installation of control apparatus), fees and compliance costs will be eliminated. The costs savings Statewide for the woodworking industry will be approximately $15,000 per year, in fees alone. For air pollution control apparatus no longer subject to permitting, the total annual reduction in fees paid to the Department is estimated to be $125,000 per year.

For those types of equipment which are shifted by the proposed amendments from category II to category I applications, fees will be substantially reduced, from $1,000 per piece of equipment to $250.00 per piece of equipment. Overall, an estimated 200 applicants per year will benefit from the reduced permit fees, resulting in a savings to the regulated public of approximately $150,000 per year.

The proposed amendments eliminate the fee for very minor administrative amendments, such as name or address changes. This will have a beneficial economic impact on the regulated community. The proposed changes to the processing of the remaining administrative amendments and seven-day-notice changes will have no economic impact because neither the fee, nor the basic processing of these changes, is affected. The proposed amendments would allow some equipment and operational changes to be reported as seven-day-notices ($200.00), rather than alterations ($1,000). This would save $800.00 per change. The Department estimates that 200 changes per year will become seven-day-notices, resulting in a total permit fee savings to the regulated community of $160,000 per year.

The proposed addition of "Environmental Improvement Pilot Tests" as a specific category of application with fees equivalent to category one permits will decrease costs to persons performing such field tests because the new approval process replaces a more expensive, full permit approval. Currently, such equipment is either approved informally by letter or through the normal permitting process. The new approval format is intended to streamline decisions consistent with the time frames of curent approvals by letter, while including a specific reference to such a category of applications in the rules so all persons are aware of, and can take

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advantage of, the Department's efforts to expedite such approvals. The Department's goal is to issue such approvals within 30 days. The $250.00 fee for applications for "Environmental Improvement Pilot Tests" is consistent with a category one application fee and is lower than the category two fee, which would likely otherwise apply. Lower fees may encourage testing of environmental improvements. Also, the Department's review will be streamlined, which reduces costs and further justifies a lower fee. Since such tests are of limited duration and typically involve small levels of emissions, a reduced level of review and fee is appropriate. If a test should go beyond 90 days, the amendments provide for approval of extension of the test with an additional fee. A more thorough evaluation will be conducted for any such extensions and will consider the data generated by the initial 90 day test period. Based on past experience with such testing, most are completed in less than 30 days, so very few tests would be for more than 90 days. The $250.00 fee is more than the current $0 fee for approval by letter (which is justified by the fact that the Department does incur costs in processing these approvals), and is less than the current $1,000 total fees for typical category two applications. Overall the cost is expected to be less. The Department estimates the 50 "Environmental Improvement Pilot Tests" approvals will be issued yearly. The annual cost for these approvals at $250.00 per application would be $12,500, which is considerably less than the $50,000 cost if all were treated as category two permits.

Some of the proposed changes will raise the cost of complying with the rules. The proposed addition of large burners (added to the definition of substantial component) and equipment which emits toxics will bring more equipment into the permitting program. Compliance costs and fees for these facilities will increase. The Department estimates that 100 source operations per year will be affected by this provision. At $1,000 per application, overall fee costs would increase by $100,000 per year.

Small paint spray operations will be required to obtain preconstruction permits and operating certificates; however, most of these operations are presently required to be permitted because of size or control device. The Department estimates that 10 paint spray operations per year will be affected by this new provision. At $250.00 per application, overall fee costs statewide would increase by $2,500 per year.

Although newspaper printing presses were previously subject to the rules, some remained without permits because of confusion regarding the rules' applicability (See above discussion of N.J.A.C. 7:27-8.2(a)20). Therefore, the proposed amendment clarifying that newspaper printing presses require a permit would require permit fees for this industry of $1,000 per facility if all printing presses at a facility are the same type with respect to inks and other chemicals used. If they are not, fees of $350.00 would be assessed for each piece of dissimilar equipment included in a single application. (Pursuant to proposed revisions to the fee schedule similar equipment can be grouped together for the purpose of fee determination.)

Subchapter 22

In a document published by EPA entitled "The Regulatory Impact Analysis and Regulatory Flexibility Act Screening for Operating Permits Regulations" (EPA, document #450/2-91-011), EPA estimates the annualized cost for the first five year implementation period to a state agency to be $9,500 per year to issue and administer an operating permit for a larger facility. The Department used these findings as a general comparison to the findings generated independently by the Department and determined that the costs generated by the Department's workload analysis are consistent with EPA's national cost estimates.

The costs of the operating permit program to the State will be covered by the fees required by Title V. The Department estimates that average operating permit fees will be $12,000 in fiscal year 1995 for the average major New Jersey facility. This estimate is derived in the Workload Analysis and Fee Determination reports compiled by the Department. The $12,000 that would be charged to the average major New Jersey facility in 1995 is consistent with the $9,500 that was estimated by EPA in 1992 to be the national average cost for Federally mandated activities. A somewhat higher cost is expected because the New Jersey 1995 estimated cost accounts for inflation and the fact that major industrial sources in New Jersey are generally more complex than the average major industrial source nationally. This is because New Jersey has a large chemical and pharmaceutical industry, whose facilities have many varied and complex operations, including many batch plant operations. Also, New Jersey's workload analysis is more detailed than the Federal analysis, and therefore, the New Jersey cost estimates are likely to be more accurate.

The requirement to prepare and submit a comprehensive operating permit application will create an additional cost to the applicant. This cost will be incurred through administrative and technical activities. For example, administrative cost may include personnel training, attendance at Department meetings, coordination with the Department, filing, legal assistance and the actual paperwork involved in assembling a comprehensive operating permit. Technical activities may include emission calculations, technical descriptions of operations and the selection of monitoring measures. The majority of the administrative activities will be common to the entire facility and may be characterized as a base cost. The cost of the technical preparation of the operating permit application will be proportional to the number of source operations, and its complexity and costs will vary considerably.

The administrative cost resulting from subchapter 22 is estimated to be on the average $5,000 for each facility. For a very large and complex facility, this amount could be many times greater. For a simpler facility, the base cost may be much lower.

The technical cost to prepare an application may vary from $100.00 to $10,000 per significant source operation, depending on the complexity of the applicable requirements. The Department estimates that the vast majority of the source operations affected by subchapter 22 will not be complex. Therefore, preparation of an operating permit application is likely to be at the lower end of the cost spectrum, probably about $500.00 per significant source operation. There are an average of 30 significant sources per major facility in New Jersey. Therefore, the average cost per facility for the technical work required to prepare and submit an operating permit application is estimated to be $15,000.

To determine a total operating permit application preparation cost, the Department has added the estimated administrative cost ($5,000) to the estimated technical preparation cost ($15,000), arriving at an average figure of $20,000 per facility. Because a renewal of an operating permit will focus on changes to the facility, the Department expects the cost for renewal to be about half of this, approximately $10,000.

The administrative cost of permit modifications, usually $250.00 to $1,000 per source operation, would be about the same overall as current costs. Some costs will be reduced because of the previously discussed streamlining of the preconstruction permit process. Some costs will be increased because of the need to respond to public comments on some proposed significant modifications, which did not previously require comment.

Significant costs will also be associated with compliance of permit conditions concerning testing, monitoring, recordkeeping and reporting. The precise contents of those provisions are still to be determined by separate EPA rulemaking; therefore, the Department cannot at present reasonably estimate the cost of complying with them.

Overall, the economic impacts to the average major facility subject to subchapter 22 can be summarized by adding the average initial cost of preparing an application to the annual fee (about $12,000 per year). Since the cost of preparing the operating permit application is incurred only once in five years, the annual economic impact of preparing an application to an average facility is $20,000 divided by five years or $4,000 per year. Accordingly, the average annual economic impact to the 900 facilities subject to subchapter 22 is the $4,000 annualized permit preparation cost plus the annual operating permit fee of $12,000, resulting in an average annual cost of $16,000 in FY95.

The Department's goal in developing the proposed rules was to structure the fee schedule and the implementation strategy in a manner that minimizes the economic impact to the regulated community, meets the mandates of Part 70, and maximizes protection of the environment. For example, subchapter 22 includes operating flexibility provisions that provide streamlined methods to modify the permit for non-significant changes. The seven-day-notice provision will result in fewer permit alterations that require preconstruction permits. This new flexibility will make the preparation of documents for many permit modifications less costly to the regulated community than the systems presently in place.

In addition, the fee schedule was developed by carefully analyzing in detail the projected workload by Department staff and introducing cost saving measures including: phasing in the initial operating permits with an interim program; planning for a selective audit program for inspections and test observations; and proposing to hold consolidated hearings on groupings of draft operating permits. With such planning the originally projected staffing need was reduced by about one-third the final workload analysis. During the first two years of implementation of the

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operating permit program, the hiring of staff will be phased in. This phased in approach will contain the costs to fund the operating permit program during the first two years.

The Department seeks constructive suggestions on other ways to implement an operating permit program that fully complies with the standards of EPA's Part 70 rule at the lowest possible cost. Such suggestions will be seriously considered whether they are directly relevant to this rule or concern indirect implementation issues, such as application format.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has made the following determinations as to small businesses regarding the proposed new rules and amendments to existing rules. The New Jersey Regulatory Flexibility Act defines small businesses as "any business which is a resident in this State, independently owned and operated and not dominant in its field, and which employs fewer than 100 full time employees."

The proposed amendments to subchapter 1 are organizational and will not affect small businesses. The proposed amendments to subchapter 18 are administrative and will not affect small businesses.

Most of the proposed amendments to subchapter 8 will affect small businesses in a positive way by reducing the costs of compliance with this subchapter. There will be a reduction in application fees for certain equipment at small businesses and a reduction in the fee for minor changes, such as name and address changes. If a control apparatus is attached to equipment which does not require a permit, the control apparatus will no longer require a permit. Some small woodworking equipment will become exempt from permitting requirements altogether.

The proposed exemptions in subchapter 8 for small woodworking operations and allowing voluntary installation of control apparatus will affect small businesses more than any other businesses. For these operations, both the fees and compliance costs will be eliminated. Also, the reclassification of certain operations to category I applications will affect more small businesses than other businesses. This will provide a beneficial effect by reducing fees and compliance costs to small businesses.

The proposed amendments in subchapter 8 will not require small businesses to hire additional professional help, or to make substantial expenditures of capital. It is expected that the proposed amendments will only marginally affect the compliance costs for small businesses, and that those amendments will reduce overall costs to small businesses.

Subchapter 22

The proposed subchapter 22 will subject to the new operating permit process an estimated 300 small businesses that are major sources and therefore required by the CAA to be subject to the process. To minimize the effects of subchapter 22 on small businesses, New Jersey will issue general operating permits for some source categories which are typical to small businesses. These permits will allow groups of small businesses in the same industry to apply for such general permits, thus minimizing the complexity of the permit application and its costs.

New Jersey has also established a Small Business Technical Assistance Program. This program will be expanded to assist small businesses in determining applicable requirements of subchapter 22 and completing their operating permit application. The Small Business Technical Assistance Program (SBAP) was created because small business frequently lacks the technical expertise and financial resources necessary to evaluate and determine the appropriate mechanisms for compliance with air pollution regulations. The major tasks that the SBAP is intended to provide to small businesses are: access to technical expertise and compliance information; access to methods of pollution prevention and accidental release prevention and detection; timely notification of their rights; and assistance in understanding their obligations to comply with the Federal and State regulations. The SBAP will accomplish these tasks by developing guideline documents and providing the information through an electronic bulletin board, a telephone hotline, and workshops/seminars. It will be fully operational by November 1994. Additional staff will be phased in over the next several years.

The fees that subchapter 22 will impose on emissions or equipment will affect small businesses. The fact that small businesses for the most part will have low emissions and few pieces of equipment requiring permits will reduce the costs. As an example, a typical small business may emit a total of 25 tons of actual emissions, and the emissions fee amount would be about $750.00 in 1995, after adjusting the $25.00 per ton for projected increases in the CPI. Another typical small business might have five significant source operations, and the alternative annual equipment fee would also be about $750.00. Assuming 300 small businesses require operating permits, the total annual cost to New Jersey small businesses would be about $225,000.

In addition, small businesses will, like other facilities subject to the proposed new rules, incur the costs set forth in detail above in the Economic Impact statement. These costs include those for the preparation of an application for an operating permit and for complying with other requirements of the rule, such as those related to monitoring, recordkeeping and reporting. Because these costs will vary significantly based upon the size and complexity of each facility, small businesses will tend to incur substantially lower costs than the average facility, that is, substantially less than $4,000 per year per facility. Most small businesses should not need to hire a consultant to assist in complying with the proposed new rule, but some may prefer to hire a professional engineer or other consultant for that purpose.

In summary, subchapter 22 will have an effect on those 300 small businesses that have the potential to emit major quantities of air contaminants. This effect will be kept to a minimum by the Department's efforts to structure this new proposal to include operating flexibility, general operating permits, a Small Business Technical Assistance Program and a fee schedule that will have less impact on small facilities. The Department has taken the steps appropriate to minimize the effect of the rules on small business to the extent permitted by Federal and State law and the Department's obligation to protect the public health, safety and welfare.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:27-1.4 Definitions

The following words and terms, when used in this chapter, [shall] have the following meanings, unless the context clearly indicates otherwise.

. . .

"Preconstruction permit" means a "Permit to Construct, Install or Alter Control Apparatus or Equipment" issued by the Department pursuant to the Air Pollution Control Act of 1954, and in particular N.J.S.A. 26:2C-9.2.

. . .

"Responsible official" means one of the following:

1. For a corporation:

i. A president, secretary, treasurer, or vice-president of the corporation, who is in charge of a principal business function;

ii. Any other person who performs similar policy or decision-making functions for the corporation; or

iii. A duly authorized representative of the person in 1i or ii above, if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a preconstruction permit or certificate, or an operating permit, and either:

(1) The facilities for which the representative is responsible employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars); or

(2) The delegation of authority to the representative is approved in writing in advance by the Department;

2. For a partnership or sole proprietorship: a general partner or the proprietor, respectively;

3. For a municipality, State, Federal, or other public agency: either a principal executive officer or ranking elected official. For the purposes of this subchapter, a principal executive officer of a Federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency (for example, a Regional Administrator of EPA); or

4. For affected facilities under Title IV of the Clean Air Act:

i. The designated representative in so far as actions, standards, requirements, or prohibitions under Title IV of the Clean Air Act or the regulations promulgated thereunder are concerned; and

ii. The designated representative for any other purposes under 40 CFR Part 70.

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7:27-1.31 Right to enter

(a) The Department and its representatives shall have the right to enter and inspect at any time, any facility or building, or portion thereof, including all documents and equipment on the premises, in order to ascertain compliance or noncompliance with this chapter or with any preconstruction permit, certificate, operating permit, order, authorization or other legal document issued pursuant thereto, or to verify any information submitted to the Department. This right is absolute and shall not be conditioned upon any action by the Department, except the presentation of appropriate credentials as requested, and compliance with appropriate safety standards. This right includes, but is not limited to, the right to:

1. Enter upon the premises of the facility;

2. Sketch or photograph any portion of the facility;

3. Enter upon the premises of a facility where records are maintained under the conditions of the preconstruction permit, certificate or operating permit;

4. Review any records that must be kept under the conditions of the preconstruction permit, certificate or operating permit;

5. Copy or photograph any records that must be kept under the conditions of the preconstruction permit, certificate or operating permit;

6. Inspect any part of the facility, including any equipment (including any equipment used for monitoring and any air pollution control apparatus), practices, or operations, regulated or required under the preconstruction permit, certificate or operating permit;

7. Interview any employee or representative of the owner or operator; and

8. Test or sample any substance or material.

(b) No person shall obstruct, hinder or delay the Department or its representatives in its exercise of its rights under (a) above.

(c) An owner or operator of a facility, and any employee or representative of any owner or operator, shall, upon request, assist the Department and its representatives in the performance of any inspection. Such assistance shall include, but shall not be limited to, making available sampling equipment and facilities necessary to conduct sampling and to determine the nature and quantity of any air contaminant emitted by the facility.

(d) During any sampling or testing conducted by the Department, any equipment, and all components connected to, attached to, or serving the equipment, shall be operated under normal operating conditions, or under conditions set forth in any preconstruction permit, certificate, operating permit, order or other State or Federal authorization covering the equipment.

7:27-1.39 Certification of information

(a) Except pursuant to (c) below, any person who submits an application, report or other document to the Department shall include, as an integral part of the application, report or other document, the following two-part certification:

1. A certification, signed by the individual or individuals (including any consultants) with direct knowledge of and responsibility for the information contained in the certified document. The certification shall state:

"I certify under penalty of law that I believe the information provided in this document is true, accurate and complete. I am aware that there are significant civil and criminal penalties, including the possibility of fine or imprisonment or both, for submitting false, inaccurate or incomplete information."

2. A certification signed by a responsible official, as defined at N.J.A.C. 7:27-1.4, which states:

"I certify under penalty of law that I have personnally examined and am familiar with the information submitted in this document and all attached documents and, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete. I am aware that there are significant civil and criminal penalties, including the possibility of fine or imprisonment or both, for submitting false, inaccurate or incomplete information."

(b) The certification at (a)2 above shall not be required if the individual required to sign the certification in (a)1 above is the same individual required to sign the certification in (c) above.

(c) For the purposes of emissions statements requirements pursuant to N.J.A.C. 7:27-21, the specific certification required by N.J.A.C. 7:27-21 shall be used.

7:27-8.1 Definitions

The following words and terms, when used in this subchapter, [shall] have the following meanings, unless the context clearly indicates otherwise.

. . .

"Administrative amendment" means a revision of information in a preconstruction permit or a certificate pursuant to the procedures for administrative amendments at N.J.A.C. 7:27-8.14.

. . .

["Alteration" means any change made to equipment or control apparatus or the use thereof, except for change reported to the Department pursuant to N.J.A.C. 7:27-8.3(c) as an amendment of the permit in effect and repair or maintenance. Alteration includes, but is not limited to:

1. Change in the location of the point of discharge of any air contaminant from equipment or control apparatus into the outdoor atmosphere, unless the change is authorized in the permit or certificate in effect;

2. Replacement of equipment or control apparatus or of any substantial component thereof if:

i. The replacement equipment or control apparatus is not the same kind as that which is being replaced;

ii. The replacement equipment or control apparatus is not equivalent to, or better than, for the purpose of air pollution control, that which is being replaced;

iii. The date of approval of the permit authorizing the installation of the equipment or control apparatus being replaced is more than five years prior to the date of installation of the replacement equipment or control apparatus; or

iv. No permit is in effect for the equipment or control apparatus;

3. The introduction of any new raw material to equipment or control apparatus for which no certificate is in effect, including the change of contents of a storage tank for which no certificate is in effect;

4. Any reconfiguration to an alternate configuration not authorized in the permit in effect;

5. Any of the following changes to equipment or control apparatus, or to the use thereof, if the change may increase the concentration or rate of any air contaminant emission:

i. Addition, replacement, or removal of auxiliary devices or appurtenances;

ii. Change in the relative use, expressed in percent by weight, of any raw material in the operation of equipment or control apparatus or in the process, including the introduction of a raw material not authorized in the permit or certificate in effect; or

iii. Change in the process in which the equipment or control apparatus is used;

6. Increase in the concentration or rate of emission of any air contaminant above that authorized by the permit and certificate in effect;

7. Emission of any air contaminant not authorized by the permit and certificate in effect;

8. Any change to a stack or chimney or the use thereof, including any change to a stack dispersion parameter including, but not limited to, temperature, velocity, direction, or volumetric flow rate, if:

i. The change is not in compliance with the stack height regulations promulgated at 40 CFR 51;

ii. The change may result in an increase in the ambient concentration of any air contaminant; or

iii. No permit is in effect for the equipment or control apparatus;

9. Any change in the concentration of any air contaminant in the influent to existing control apparatus above that authorized in the permit or certificate;

10. Any increase in the total hours of operation per time period or the rate of production above that authorized in the permit or certificate; and

11. Any change to equipment or control apparatus, or to the use thereof, if the change will result in a contravention of any State or

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Federal ambient air quality standard, any provision of N.J.A.C. 7:27, or any condition or approval of any permit or certificate in effect.]

"Alteration" means any change made to equipment or control apparatus or the use thereof set forth as an alternation at N.J.A.C. 7:27-8.16. In respect to a facility for which an operating permit has been issued pursuant to N.J.A.C. 7:27-22, this term shall include any change which would constitute a significant modification or a minor modification of the operating permit.

"Alternative operating scenario" means a plan for operating a facility or a portion thereof using methods or processes, which are different from other methods or processes approved for use at the same facility, or the same portion thereof, at different times. For example, using a vessel to make product A on Tuesdays and product B on Wednesdays.

...

["Amendment" means any revision of information in a permit or operating certificate in effect which does not reflect a change in the quality, nature, or quantity of emissions to the outdoor atmosphere or a change in the effect of the emissions on ambient air quality. The term does not include the modification of information in a permit or certificate to reflect alteration of equipment or control apparatus.]

...

"Applicable Federal requirement" means any of the following standards, provisions or requirements as they apply to any source operation in a facility which is subject to this subchapter. Applicable requirements include requirements that have been promulgated or approved by EPA through rulemaking, but have future-effective compliance dates:

1. Any standard or other requirement provided for in New Jersey's approved SIP (or FIP, if applicable), including any approved revisions;

2. Any provision or condition of any preconstruction permit issued pursuant to N.J.A.C. 7:27-8;

3. Any NSPS or other standard or requirement under 42 U.S.C. §7411 including 42 U.S.C. §7411(d);

4. Any standard or other requirement concerning HAPs under 42 U.S.C. §7412, including any requirement concerning accident prevention under 42 U.S.C. §7412(r)(7);

5. Any standard or other requirement of the acid deposition control program under Title IV of the CAA or the regulations promulgated thereunder;

6. Any requirement established pursuant to the provisions for monitoring in Title V of the CAA at 42 U.S.C. §7661c(b) or pursuant to the monitoring requirements at 42 U.S.C. §7414(a)(3);

7. Any standard or other requirement governing solid waste incineration under 42 U.S.C. §7429;

8. Any standard or other requirement for consumer and commercial products under 42 U.S.C. §7511b(e);

9. Any standard or other requirement for marine tank vessels under 42 U.S.C. §7511b(f);

10. Any standard or other requirement of the program to prevent or control the emission of air contaminants from outer continental shelf sources under 42 U.S.C. §7627;

11. Any standard or other requirement of the regulations promulgated to protect stratospheric ozone under Title VI of the CAA, unless EPA has determined that such a requirement need not be contained in an operating permit;

12. Any of the following, but only as it would apply to temporary facilities permitted pursuant to 42 U.S.C. §7661c(e);

i. A NAAQS; or

ii. An increment under 42 U.S.C. §7473; or

iii. A visibility requirement under 42 U.S.C. §7491 or 7492.

"Applicable requirement" means any applicable State requirement or applicable Federal requirement.

"Applicable State requirement" means any provision, standard or requirement in any statute or rule, as it applies to a facility or source operation which is subject to this subchapter, but is not an applicable Federal requirement. This term includes requirements that have been promulgated by the Department and submitted to EPA as SIP revisions but have not yet been approved by EPA. An example of an applicable State requirement is N.J.A.C. 7:27-8.8(f), as it relates to the control of nuisance odor.

...

"Architectural coating" means a surface coating formulation applied and dried at ambient conditions, and used to coat all or parts of stationary structures and their appurtenances, such as buildings, bridges, the interior or exterior of houses, and other items such as signs, curbs, and pavements.

...

"Banking" means [reserving approved emission reductions for future use] **the reservation of creditable emission reductions,** pursuant to N.J.A.C. 7:27-18, **for future use as emission offsets.**

...

"Category I" means **the class of applications for preconstruction permits or certificates for** the following types of [new or altered] equipment [and control apparatus which require a permit or certificate]:

1.-8. (No change.)

9. Any paint spray [booth] **operation or other surface coating operation** that has particulate control apparatus and that uses less than one half gallon of paint per hour and the particulate control apparatus serving the spray booth; this does not include any paint spray [booth] **operation or surface coating operation** which emits any TXS; [and]

10. Any **applicable** [control apparatus that solely serves one or more] laboratory hoods, ducts, vents, or similar devices used as conduits for exhausting fumes from laboratory operations[.];

11. Any applicable enclosed sandblasting equipment that has a control apparatus that achieves a minimum particulate control efficiency of 99 percent;

12. Any applicable plastics grinding equipment; and

13. Any applicable open top surface cleaner which is equipped with a cover and free-board chiller. This does not include any surface cleaner which uses a HAP.

"Category II" means **the class of application for a preconstruction permit or certificate for** any type of new or altered equipment [and control apparatus which requires a permit or certificate], except those types which are defined above as belonging to Category I.

...

"Clean Air Act" or "CAA" means the Federal Clean Air Act (42 U.S.C. 7401 et seq.) which consists of Public Law 159 (July 14, 1955; Stat. 322) and all subsequent amendments thereto.

...

"Delivery vessel" means any mobile storage tank including, but not limited to, tank trucks, railroad tank cars, or marine tank vessels.

"Department" means the New Jersey Department of Environmental Protection **and Energy.**

...

"Environmental improvement pilot test" means a sampling and analytical program using prototype equipment or processes on a temporary basis for the purpose of collecting data necessary for the design of a full scale process to achieve an environmental improvement, or for the purpose of determining the feasibility of using the equipment or process for a particular environmental improvement.

...

"Freeboard chiller" means a set of condensing coils which are located peripherally along the free board and which condense the solvent vapor before they escape from the surface cleaner.

...

"Graphic arts operation" means the application of one or more surface coating formulations non-uniformly across a surface, using one or more printing units, together with any associated drying or curing areas. A single graphic arts operation ends after drying or curing and before other surface coating formulations are applied. For any web line, this term means an entire application system, including any associated drying ovens or areas between the supply roll and take-up roll or folder. This term does not include any surface coating operation.

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"Hazardous air pollutant" or "HAP" means an air contaminant listed by EPA as a HAP, pursuant to 42 U.S.C. 7412(b). That list is incorporated by reference herein, together with all amendments and supplements. A copy of the list is available from the Department at the address set forth at N.J.A.C. 7:27-8.4(a).

...

"Install" means to carry out final setup activities necessary to provide the equipment or control apparatus with the capacity for use or service. This term includes, but is not limited to, the connection of the equipment and control apparatus, associated utilities, piping, ductwork and conveyor systems. This term does not include **the term** "construct," **as defined above,** nor the reconfiguration of equipment and control apparatus to an alternate configuration specified in the **preconstruction or operating** permit application and approved by the Department.

...

"Operating permit" means a permit issued pursuant to N.J.A.C. 7:27-22 by the Department to authorize the use of one or more source operations from which air contaminants may be emitted.

...

["Permit" means a "Permit to Construct, Install or Alter Control Apparatus or Equipment" issued by the Department pursuant to the Air Pollution Control Act of 1954, specifically N.J.S.A. 26:2C-9.2].

"Person" means **any individual or entity and shall include, without limitation,** corporations, companies, associations, societies, firms, partnerships and joint stock companies, as well as individuals, and **shall also include, without limitation,** all political subdivisions of this State or any agencies or instrumentalities thereof.

"Plastics grinding equipment" means any type of machinery which is used to chop, grind or cut any plastic material for reintroduction of the material into the manufacturing process. This includes any conveying and product collection equipment associated with the grinding machinery.

...

"Potable water" means any water used or intended to be used for drinking or culinary purposes.

...

"Preconstruction permit" means a "Permit to Construct, Install or Alter Control Apparatus or Equipment" issued by the Department pursuant to the New Jersey Air Pollution Control Act and in particular N.J.S.A. 26:2C-9.2.

...

"Reconfiguration" means a change in the setup of equipment or control apparatus, or both, to an alternate configuration. This term also includes reorientation or reconnection into an alternate pattern of equipment or control apparatus, or both. This term does not include a change in the location of equipment or control apparatus from that specified in the **preconstruction** permit.

...

"Seven-day-notice change" means a change made pursuant to the procedures at N.J.A.C. 7:27-8.15.

...

"Stationary storage tank" means any immobile storage tank. This term also includes any delivery vessel, excluding a railroad tank car, used for storing VOC at a facility for more than one month.

...

"Substantial component" means, **in respect to replacement, any equipment or control apparatus, or** any component of equipment or control apparatus, if:

1. The total fixed capital cost [of the component] exceeds:

i. (No change.)

ii. For Category II sources, 50 percent of the total fixed capital cost of replacement [of the equipment or control apparatus] or $20,000 as calculated 1989 dollars, whichever is greater; [or]

2. The **equipment or control apparatus, or the** component is designated in the conditions of approval of the **preconstruction** permit in effect as a substantial component[.]; **or**

3. The component is a burner having a rated heat input of 10 million BTU per hour or greater.

...

"Surface coating operation" means the application of one or more surface coating formulations uniformly across a surface, using one or more coating applicators, together with any associated drying or curing areas. A single surface coating operation ends after drying or curing and before other surface coating formulations are applied. For any web coating line, this term means an entire coating application system, including any associated drying ovens or areas between the supply roll and take-up roll, that is used to apply surface coating formulations onto a continuous strip or web. This term does not include any graphic arts operation.

...

"Temporary facility" means a facility which, by design, is intended to be operated at more than one location and which is relocated more than once in five years.

...

7:27-8.2 Applicability

(a) New or altered equipment and control apparatus for which a **preconstruction** permit and an operating certificate are required, pursuant to the provisions of N.J.A.C. 7:27-8.3, include:

[1. All control apparatus, except any control apparatus used solely to purify intake air fed into a source operation;]

1. Any equipment used in a commercial or industrial paint spray operation, except for equipment used in architectural coating operations;

2. Equipment used in a manufacturing process involving a surface coating **operation or graphic arts operation** including, but not limited to, spray and dip painting, roller coating, electrostatic depositing, surface stripping or spray cleaning, from which direct or indirect emissions of air contaminants occur and in which the quantity of coating or cleaning material used in any source operation is equal to or greater than one half gallon in any one hour;

3.-14. (No change.)

15. [Waste] **Any waste** or water treatment equipment which may emit air contaminants[,] including, but not limited to, air stripping equipment, aeration basins, [and] surface impoundments, **lagoons, sludge tanks, dewatering equipment, soil cleaning equipment, conveying equipment, digesters, thickeners, flocculators, driers, fixation equipment, composting equipment, pelletizing equipment and grit classifying equipment; except for aeration basins, lagoons, and settling basins at publicly owned treatment works or domestic treatment works;**[. A permit is not required for:

i. Any water treatment equipment] if the concentration **in the water** of each TXS [included in N.J.A.C. 7:27-17 does not] **equals or** exceeds 100 parts per billion by weight [and] **or** the total concentration **in the water** of VOC [does not] **equals or** exceeds 3,500 parts per billion by weight;

[ii. Potable water treatment equipment, except air stripping equipment with a capacity greater than 100,000 gallons per day;

iii. Aeration basins and lagoons at publicly owned treatment works; or

iv. Aeration basins and lagoons at domestic treatment works;]

16. Equipment used for the purpose of venting a closed or operating dump, sanitary landfill, hazardous waste landfill, or other solid waste facility, directly or indirectly into the outdoor atmosphere **including, but not limited to, any transfer station, recycling facility, or municipal solid waste composting facility;** [and]

17. Any source operation which has the potential to emit any TXS at a rate greater than [the exception rate specified in N.J.A.C. 7:27-17.] **0.1 pounds per hour (45.4 grams per hour);**

18. Any equipment required to have air pollution control apparatus pursuant to any applicable provisions of N.J.A.C. 7:27;

19. Any control apparatus serving equipment for which a permit is required pursuant to this section;

20. Newspaper printing equipment subject to N.J.A.C. 7:27-8.2(a)2. For newspaper printing equipment in operation on or before (operative date of this proposal), applications must be filed in accordance with this subchapter by September 1, 1994; or

21. Any equipment not specified in (a)1 through (a)20 above but which has the potential to emit;

i. Total dioxin and furans, in quantities greater than 0.001 pounds per year;

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ii. Benzidine or bis (chloromethyl) ether, in quantities greater than 0.6 pounds per year;

iii. n-Nitrosodimethylmine, in quantities greater than 2.0 pounds per year;

iv. Hexavalent chromium compounds, in quantities greater than 4.0 pounds per year;

v. Hydrazine, in quantities greater than 8.0 pounds per year;

vi. Arsenic and arsenic compounds or 2-nitropropane, in quantities greater than 10.0 pounds per year;

vii. Any HAP listed in table A in Appendix I of this subchapter in quantities greater than 20 pounds per year;

viii. Any HAP listed in table B in Appendix I of this subchapter in quantities greater than 200 pounds per year; or

ix. Any HAP not listed in i(a)21 through viii above in quantities greater than 2,000 pounds per year.

(b) New or altered equipment and control apparatus for which a **preconstruction** permit and an operating certificate are not required, notwithstanding the provisions of (a) above, include:

1. A storage tank maintained under a pressure greater than one atmosphere provided that any vent serving such storage tank has the sole function of relieving pressure under emergency conditions; [and]

2. [Tanks] **Storage tanks,** reservoirs, containers, [and] **or** bins used on any farm for the storage of agricultural commodities produced by or consumed in the farm's own operations. This exemption does not include **storage** tanks, reservoirs, containers [and] **or** bins used by distributors of agricultural commodities or by research facilities which develop products for use in agricultural production[.]**;**

3. Potable water treatment equipment, except air stripping equipment with a capacity greater than 100,000 gallons per day;

4. Aeration basins, lagoons and settling basins at publicly owned treatment works or domestic treatment works;

5. Equipment which is used for the sole purpose of woodworking by sanding, drilling, cutting or planing, unpainted wood or wood products, and which vents into a room; and

6. Control apparatus used solely to purify intake air fed into a source operation.

7:27-8.3 General provisions

(a) No person shall construct, install, or alter any equipment or control apparatus without first having obtained a [Permit to Construct, Install or Alter Control Apparatus or Equipment] **preconstruction** permit, except as provided at N.J.A.C. 7:27-[8.27] **8.17**.

(b) No person shall use or cause to be used:

1. Any new or altered equipment or control apparatus without first having obtained an operating certificate, [or] a temporary operating certificate, **or an operating permit,** except as provided at N.J.A.C. 7:27-[27] **8.17**; or

2. (No change.)

[(c) Any person holding a permit or certificate shall keep the information in the permit or certificate up to date. Such person shall report any of the following changes to the Department within 120 days after the occurrence of the change, as an amendment of the permit or certificate, provided that the change does not constitute an alteration as defined in N.J.A.C. 7:27-8.1:

1. Change in business name, division name, or plant name; mailing address; company stack designation; telephone number; or name of plant contact.

2. Transfer of ownership of the equipment or control apparatus for which a permit or certificate is in effect;

3. Change in the contents of a storage tank for which a permit is in effect, provided such change does not involve the use or storage of any TXS;

4. The introduction of a raw material not authorized in the permit or certificate in effect;

5. Replacement of equipment or control apparatus or of any substantial component thereof, provided that the date of installation of the replacement equipment or control apparatus is less than five years after the date of approval of the permit authorizing the installation of the replaced equipment or control apparatus; or

6. Any of the following changes to a stack or chimney or the use thereof, provided that the change is in compliance with the stack height regulations promulgated at 40 CFR 51:

i. Change in the number of stacks or chimneys serving the equipment or control apparatus, provided that the change does not result in any discharge height less than that of the tallest stack or chimney existing prior to the change;

ii. Decrease in the diameter of a stack or chimney, provided that the exhaust is vented upward;

iii. Replacement of an existing stack or chimney with a taller stack or chimney, provided that this results in an effective stack height which is no less than that existing before the change; or

iv. Increase in the exit temperatures or volume of gas emitted from a stack or chimney.]

(c) A permittee shall make a change to equipment or control apparatus, or to the use, thereof, which is an administrative amendment, seven-day-notice change, or an alteration in accordance with the procedures set forth at N.J.A.C. 7:27-8.14, 8.15, or 8.16, respectively.

(d) Any person holding a **preconstruction** permit or certificate shall make said **preconstruction** permit or certificate, together with any **administrative** amendments, **seven-day-notice changes, or alterations reflecting changes** thereto, readily available for inspection on the operating premises.

(e) No person shall use or cause to be used any equipment or control apparatus unless[:

1. All conditions and provisions of the permit and certificate are fulfilled; and

2. All] **all** components connected or attached to, or serving the equipment or control apparatus, are functioning properly and are in use in accordance with the **preconstruction** permit and certificate **and all conditions and provisions thereto.**

(f) A **preconstruction** permit or certificate shall not be transferable either from the location authorized in the **preconstruction** permit **or certificate** in effect to another or from any one piece of control apparatus or equipment to another.

(g) [The possession of a permit or certificate does not relieve any person from the obligation to comply with all other provisions of N.J.A.C. 7:27.] **(Reserved.)**

(h) [Permits] **Preconstruction permits** and certificates issued under this subchapter are based on the potential for emission of air contaminants only and do not in any way relieve the applicant from the obligation to obtain necessary permits from other governmental agencies and to comply with all other applicable Federal, State, and local rules and regulations.

(i) (No change.)

(j) No person holding any **preconstruction** permit or certificate shall suffer, allow, or permit any air contaminant, including an air contaminant detectable by the sense of smell, to be present in the outdoor atmosphere in such quantity and duration which is, or tends to be, injurious to human health or welfare, animal or plant life or property, or would unreasonably interfere with the enjoyment of life or property. This shall not include an air contaminant which occurs only in areas over which the owner or operator has exclusive use or occupancy.

[(k) Any person holding a permit or certificate may decrease any of the following as an amendment of the permit or certificate, provided that the decrease does not entail any change made to equipment or control apparatus or the use thereof, or otherwise constitute an alteration as defined in N.J.A.C. 7:27-8.1:

1. Any maximum allowable rate of emission of any air contaminant or category of air contaminant limit;

2. Any maximum allowable hours of operation per time period; or

3. Any maximum allowable rate of production.]

(k) For a person seeking approval for an environmental improvement pilot test, as defined at N.J.A.C. 7:27-8.1, of air pollution control equipment or other environmental clean-up equipment, the Department will take final action on the application for the preconstruction permit or certificate within 30 days of its receipt of an administratively complete application. The approval will be

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effective for 90 days, and may be renewed by application to the Department. The fee for an environmental improvement pilot test is set forth at N.J.A.C. 7:27-8.11.

(1) Notwithstanding (b) above, no certificate is required for equipment or control apparatus at a facility for which:

1. An operating permit issued by the Department is in effect; or

2. A facility-wide permit issued by the Department pursuant to N.J.S.A. 13:1D-35 et seq. is in effect.

(m) There shall be an affirmative defense to liability for penalties for a violation of a preconstruction permit or certificate, occurring as a result of an equipment malfunction, an equipment startup, an equipment shutdown, or during the performance of necessary equipment maintenance. The affirmative defense shall be asserted and established as required by P.L. 1993. c.89 (adding N.J.S.A. 26:2C-19.1 through 2C-19.5) and any rules that the Department promulgates thereunder, and shall meet all of the requirements thereof. There shall also be an affirmative defense to liability for penalties or other sanctions for noncompliance with any technology based emission limitation in the preconstruction permit or certificate, if the noncompliance was due to an emergency as defined at N.J.A.C. 7:27-22.1, provided that the affirmative defense is asserted and established in compliance with 40 CFR 70.6(g) and meets all the requirements thereof.

7:27-8.4 Applications for **preconstruction** permits and certificates

(a) Applications for a **preconstruction** permit or a certificate, **for an administrative amendment, for an alteration,** or for a renewal [thereof] **of a certificate, and notices of seven-day-notice changes** shall be [made] **submitted** to the Department on forms obtained from the Department. Application **and notice** forms and information pertinent to applications and notices, may be requested from:

Bureau of New Source Review
Environmental Regulation Program
Department of Environmental Protection
and Energy
401 East State Street, Second Floor
CN 027
Trenton, New Jersey 08625-0027

(b) The Department may require the applicant to submit such details regarding the equipment or control apparatus as it considers necessary to determine that the equipment or control apparatus is designed to operate without causing a violation of any provisions of relevant State or Federal laws or regulations and that the equipment or control apparatus incorporates advances in the art of air pollution control developed for the kind and amount of air contaminant emitted by the applicant's equipment. Such information may include description of processes, raw materials used, operating procedures, physical and chemical nature of any air contaminant, volume of gas discharged, and such other information as the Department considers necessary. All information submitted to the Department shall be public information except that which is designated confidential in accordance with N.J.S.A. 26:2C-9.2 and in compliance with N.J.A.C. 7:27-1[.6 through 1.30.].

(c) Before an operating certificate, or any renewal thereof, is approved, the Department may require the applicant to conduct such testing as is necessary, at the discretion of the Department, to verify that the kind and amount of air contaminants emitted from the equipment or control apparatus are in compliance with the limits established in the **preconstruction** permit and certificate and that only the air contaminants approved in the **preconstruction** permit are being emitted. If such testing is required, the applicant shall:

1. Submit a source-specific testing protocol to the Department at least 60 days prior to the anticipated date of the testing, if such a protocol is required in the conditions of approval of the **preconstruction** permit or certificate;

2.-3. (No change.)

4. Give the Department at least seven days advance notice of the date and time of the start of any testing conducted pursuant to a source-specific testing protocol, except in cases where the Department has specified in the conditions of approval of the **preconstruction** permit or certificate other time requirements for notice;

5.-6. (No change.)

(d) A single application for a **preconstruction** permit or certificate may pertain to all equipment and control apparatus from which all of the air contaminants are vented through a single stack or chimney or through a single stack equivalent.

(e) Any person who is applying for a **preconstruction** permit shall submit as part of the application, an NSPS and NESHAP applicability and compliance demonstration, if the proposed equipment or the intended use of the proposed equipment is within any source category to which any NSPS or NESHAP is applicable.

(f) Upon request of the Department, and in accordance with a protocol approved in advance by the Department, the applicant for a **preconstruction** permit shall demonstrate, utilizing an air quality impact analysis conducted in accordance with (k) below and, as deemed necessary by the Department, ambient air monitoring and risk assessment, whether the maximum controlled emissions stated on the **preconstruction** permit application may cause:

1.-4. (No change.)

(g) (No change.)

(h) Any person submitting any application to the Department pursuant to this subchapter shall include, as an integral part of the application, certifications complying with N.J.A.C. 7:27-[8.24.]**1.39**.

(i) (No change.)

(j) An applicant for a **preconstruction** permit shall conduct an air quality impact analysis in accordance with (k) below if:

1.-2. (No change.)

(k) (No change.)

(l) (Reserved)

(m) An applicant for a preconstruction permit or a certificate shall list in the application all air contaminants which may be emitted from the source operation which meet the following conditions:

1. The source operation's potential to emit the air contaminant is equal to or higher than the applicable de minimis emission threshold set forth in Table C or Table D in Appendix I; or

2. The source operation may emit the given air contaminant in an amount which could reasonably be expected to be detectable by the sense of smell outside of the facility's property boundary.

(n) If a source operation will not have the potential to emit any air contaminant in an amount such that it must be listed on the application pursuant to (m)1 or 2 above, the application shall state that no air contaminant will be emitted in a quantity greater than the applicable de minimis emission threshold set forth in Table C or Table D of Appendix 1, and there will be no air contaminant emitted in an amount which could reasonably be expected to be detectable by the sense of smell at the facility's property boundary.

7:27-8.5 Public comment

(a) (No change.)

(b) The Department may seek comments from the public whenever it finds a significant degree of public interest in a **preconstruction** permit application or whenever the Department determines such comments might clarify one or more issues involved in the decision on the **preconstruction** permit application.

7:27-8.6 Denials

(a) The Department shall deny an application for a **preconstruction** permit or certificate, or a renewal thereof, if construction, alteration, or use of control apparatus or equipment pursuant to the application would result in:

1.-7. (No change.)

(b) The Department shall deny an application for a **preconstruction** permit unless the applicant shows, to the satisfaction of the Department, that the equipment incorporates advances in the art of air pollution control developed for the kind and amount of air contaminant emitted by the applicant's equipment.

(c) The Department may deny an application for a **preconstruction** permit or certificate if the applicant fails to provide all information requested by the Department within 30 days after the request, or within a longer response period if approved in writing by the Department.

(d) The Department may deny an application for a certificate, or a renewal thereof, if the applicant has failed to:

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1. (No change.)

2. Reimburse the Department within 60 days of receipt of an invoice for any of the following charges incurred by the Department:

i. The charges billed by any telephone company for the maintenance of a dedicated telephone line required by the conditions of approval of a **preconstruction** permit or certificate for the electronic transmission of data; or

ii. The charges billed by any laboratory for performing the analysis of audit samples collected pursuant to testing or monitoring required by the conditions of approval of a **preconstruction** permit or certificate.

(e) The Department shall deny an application for a preconstruction permit for a paint spray operation, unless at a minimum the operation is served by particulate control apparatus.

7:27-8.7 Approvals

(a) No person may construct, install, or alter equipment or control apparatus **for which a preconstruction permit is required pursuant to this subchapter** other than as described and authorized in an approved **preconstruction** permit. Full responsibility for adequate design and construction shall be with the person to whom the Department has issued the **preconstruction** permit.

(b) No person may operate equipment or control apparatus **for which a certificate is required pursuant to this subchapter** other than as prescribed and authorized in an approved certificate. Full responsibility for use in accordance with the provisions of the certificate shall be with the person to whom the Department has issued the certificate.

(c) No air contaminant, or category of air contaminant where accepted by the Department, shall be emitted other than those approved in the **preconstruction** permit. Any information contained in an approved application and any condition of approval thereof are subject to enforcement. This includes the following application information, which shall constitute maximum allowable limits, unless the Department establishes other limits in the conditions of approval:

1.-3. (No change.)

(d) The Department may establish conditions of approval of any **preconstruction** permit or certificate application. In the event that a discrepancy exists between the information in an application for a **preconstruction** permit or certificate and the conditions of its approval, the conditions of approval shall prevail.

(e) The Department may withdraw its approval of a **preconstruction** permit if the person to whom the Department has issued the **preconstruction** permit:

1. Does not begin construction, installation, or alteration within one year from the date of approval of the **preconstruction** permit; or

2. (No change.)

(f) (No change.)

(g) Any person to whom the Department has issued a **preconstruction** permit or certificate shall comply with all terms and conditions of any order related to the **preconstruction** permit or certificate.

7:27-8.8 Conditions of approval

(a) Upon request of the Department, any person to whom the Department has issued a **preconstruction** permit or certificate shall submit to the Department information relevant to the operation of equipment and control apparatus including, but not limited to:

1. A diagram of the facility indicating the location of any equipment and control apparatus, its applicable **preconstruction** permit and certificate number, any stack designation assigned by the Department, and any stack designation assigned by the person;

2.-3. (No change.)

(b) The Department may include, as a condition of approval, the requirement that a person to whom the Department has issued a certificate provide verification that the equipment or control apparatus is being used in compliance with the provisions and conditions of its **preconstruction** permit and certificate. Such verification may include:

1. Periodic testing of any process materials or source emissions, or measurement of the ambient concentration of any air contaminant. The testing or measurement shall be conducted in accordance with a standard testing procedure acceptable to the Department or a source-specific testing protocol approved in advance by the Department if such a protocol is required in the conditions of approval of the **preconstruction** permit or certificate;

2.-3. (No change.)

4. Reporting to the Department such information as analysis and monitoring results, data derived from measurement of air contaminant emissions and operating parameters, and other information relevant to verifying that the operation of the equipment and control apparatus is in compliance with the provisions of the operating certificate and its conditions. Such information shall, pursuant to the conditions of the **preconstruction** permit or certificate, be reported periodically, in conformance with a schedule, or within a specified number of days of the occurrence of a violation or other event.

(c) (No change.)

(d) No person to whom the Department has issued a **preconstruction** permit or certificate shall carry out, or allow to be carried out, any alteration of equipment or control apparatus unless the altered equipment or control apparatus incorporates current advances in the art of air pollution control developed for the kind and amount of air contaminant emitted.

(e) If the conditions of a **preconstruction** permit or certificate require the Department to incur any of the following charges, the person to whom the Department has issued the **preconstruction** permit or certificate shall reimburse the Department for the full amount of these charges:

1. The charges billed by any telephone company for the maintenance of a dedicated telephone line required by the conditions of approval of a **preconstruction** permit or certificate for the electronic transmission of data; or

2. The charges billed by any laboratory for performing the analysis of audit samples collected pursuant to testing or monitoring required by the conditions of approval of a **preconstruction** permit or certificate.

(f) (No change.)

(g) Any person to whom the Department has issued a **preconstruction** permit or certificate, or a renewal thereof, shall, when requested by the Department, provide such testing facilities exclusive of instrumentation and sensing devices as may be necessary for the Department to determine the kind and amount of air contaminants emitted from the equipment or control apparatus. During testing by the Department, the equipment and control apparatus shall be operated under such conditions within their capacities as may be requested by the Department. The testing facilities may be either permanent or temporary, at the discretion of the person responsible for their provision, and shall conform to all applicable laws, regulations, and rules concerning safe construction and safe practice.

7:27-8.9 Reporting requirements

(a) Upon the request of the Department, any person holding a **preconstruction** permit or certificate shall submit to the Department any record relevant to any **preconstruction** permit or certificate. Such record shall be submitted to the Department within 30 days of the request by the Department or within a longer time period if approved in writing by the Department.

(b) Any person to whom the Department has issued a **preconstruction** permit or certificate shall submit any required report in a format and on a schedule approved by the Department. Such report shall be transmitted on paper, on computer disk, or electronically, at the discretion of the Department.

(c) Any person submitting any report to the Department, including, **but not limited to,** a report submitted as [an amendment] **notice of a seven-day-notice change** of a **preconstruction** permit or certificate pursuant to N.J.A.C. 7:27-[8.3(c)]**8.14 or 8.15** shall include, as an integral part of the report, certifications complying with N.J.A.C. 7:27-[8.24] **1.39.**

(d) (No change.)

(e) Any person to whom the Department has issued a **preconstruction** permit or certificate shall provide, in each [report]

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notice of [an amendment] **a seven-day-notice change** [of permit and certificate information], specification of the date and nature of each change that has occurred. The [report] **notice** shall be submitted on forms obtained from the Department. Changes to be reported to the Department as [an amendment] **a seven-day-notice change** of the **preconstruction** permit or certificate are specified in N.J.A.C. [7:27-8.3(c).]**7:27-8.15.**

7:27-8.10 Revocation

(a) The Department may revoke its approval of a certificate or a renewal thereof, if the person to whom the Department has issued the certificate:

1. (No change.)

2. Constructs or alters, or allows to be constructed or altered, equipment or control apparatus without applying for and obtaining from the Department approval of a **preconstruction** permit for such alteration of the equipment or control apparatus;

3. Fails to allow lawful entry by authorized representatives of the Department, pursuant N.J.A.C. 7:27-[8.25] **1.31**;

4. Fails to [report to] **inform** the Department **of** a change in the **preconstruction** permit or certificate information, as required pursuant to N.J.A.C. 7:27-[8.3(c)] **8.14 or 15** and 8.9(e), as an **administrative** amendment of the **preconstruction** permit or certificate, [within 120 days of the occurrence of the change] **or as a seven-day-notice change in accordance with the procedures set forth at N.J.A.C. 7:27-8.14 or 8.15, respectively;**

5.-6. (No change.)

7. Fails to reimburse the Department within 60 days of receipt of an invoice for any of the following charges incurred by the Department:

i. The charges billed by any telephone company for the maintenance of a dedicated telephone line required by the conditions of approval of a **preconstruction** permit or certificate for the electronic transmission of data; or

ii. The charges billed by any laboratory for performing the analysis of audit samples collected pursuant to monitoring any testing required by the conditions of approval of a **preconstruction** permit or certificate; or

8. (No change.)

(b)-(c) (No change.)

7:27-8.11 Service fees

(a) Any person subject to the provisions of this subchapter shall submit with each application for a **preconstruction** permit, an operating certificate or a renewal thereof, or with a request for an **administrative** amendment, **seven-day-notice change, alteration, environmental improvement pilot test,** or a banking service, as an integral part thereof, a non-refundable base service fee in accordance with the Base Fee Schedule.

(b) Prior to taking final action on any application for a **preconstruction** permit, an operating certificate or a renewal thereof, or on any request for an **administrative** amendment, **seven-day-notice change, alteration, environmental improvement pilot test** or a banking service, the Department will invoice each applicant for any additional fees due to the Department, assessed in accordance with the Base Fee Schedule and the Supplementary Fee Schedule **below.** The applicant shall submit any fees so assessed to the Department within 60 days of receipt of the invoice.

(c)-(d) (No change.)

(e) For equipment at a facility which is subject to N.J.A.C. 7:27-22, Operating Permits, the service fees set forth at the Base Fee Schedule, items 2 and 4, and the Supplementary Fee Schedule, item 7, shall not be required for the renewal of an operating certificate which expires after July 1, 1994, or for a periodic compliance inspection performed after July 1, 1994. All other fees shall be paid pursuant to this section.

(f) A complete application fee for a preconstruction permit and certificate shall include both the preconstruction permit application fee set forth below at item 1 and the operating certificate fee set forth below at item 2.

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A. BASE FEE SCHEDULE

Activity	Basis		Amount
1. **Preconstruction** Permit Application[1]			
a. Category I	Per Application		$100.00
b. Category II	Per First New or Altered Piece of Equipment or Control Apparatus Listed in N.J.A.C. 7:27-8.2(a) per Application, **plus**		500.00
	Per Each Additional New or Altered Piece of Equipment or Control Apparatus Listed in N.J.A.C. 7:27-8.2(a) in an Application, **provided that identical equipment to be used in identical processes and using identical materials shall be treated as one piece of equipment for fee calculations**		350.00
2. Certificate Application			
a. Category I	Per Operating Certificate		150.00
b. Category II	Per Operating Certificate		500.00
3. **Administrative Amendment and Seven-Day-Notice Change**			
a. Change in business name, division name, [or] plant name; mailing address **or telephone number**; [or] company stack designation; **plant contact, responsible official, authorized representative or agent**	Per **Preconstruction** Permit	[50.00]	**0.00**
b. Correction of a typographical error			**$ 0.00**
[b.]**c.** Transfer of Ownership **or operating permit**	Per **Preconstruction** Permit		$ 50.00
d. Any decrease in maximum allowable rate of production or hours of operation per time period	**Per preconstruction permit or operating permit**		**$ 50.00**
[c]**e.** Any change listed in [N.J.A.C. 7:27-8.3(c) 3, 4, 5 or 6] **N.J.A.C. 7:27-8.15, (seven-day-notice changes)**	Per change		$200.00
4.-5. (No change.)			
6. Application for environmental improvement pilot test	**Per Application or Per extension**		**$250.00**

[1]Should both Category I and Category II equipment and control apparatus be included in a single application, the new or altered Category I equipment and control apparatus will be subject to the Category I fee; and the new or altered Category II equipment and control apparatus will be subject to the Category II fee.

B. SUPPLEMENTARY FEE SCHEDULE

(No change.)

7:27-8.14 Administrative amendments

(a) A person holding a preconstruction permit or certificate shall keep the information in the preconstruction permit or certificate up to date. Such person shall report any change listed at (b) below to the Department as an administrative amendment.

(b) The following changes shall be reported to the Department as administrative amendments:

1. A change in company name or mailing address, division name; plant name or address, name or address of each owner's agent; name or telephone number of the on-site facility manager, any additional plant contact, or of any responsible official (as defined at N.J.A.C. 7:27-1.4);

2. A change in any company stack designation;

3. Correction of any typographical error, including a mistake in the spelling, punctuation, or formatting of text, but excluding a change to any word, term, number or usage which would allow an emission increase or would constitute a seven-day-notice change, or alteration;

4. A transfer of ownership or operational control of the facility;

5. A decrease, not required by an applicable requirement, in the maximum allowable rate of emission of any air contaminant or category of air contaminants, provided that the decrease does not entail either any physical change made to equipment or control apparatus or any operational change;

6. A decrease, not required by an applicable requirement, in maximum allowable hours of operation per time period; or

7. A decrease, not required by an applicable requirement, in maximum allowable rate of production, provided that the decrease does not entail either any physical change made to equipment or control apparatus or any operational change.

(c) An application for an administrative amendment shall be made on forms available from the Department at the address in N.J.A.C. 7:27-8.4(a).

(d) If a facility is not covered by an operating permit pursuant to N.J.A.C. 7:27-22, the permittee shall notify the Department of the administrative amendment any time up to 120 days after the change is made. If the facility is covered by an operating permit pursuant to N.J.A.C. 7:27-22, the permittee may make the change to the preconstruction permit or certificate upon the Department's receipt of an administratively complete application for the administrative amendment.

(e) Within 30 days of the Department's receipt of a notice of an administrative amendment, the Department shall:

1. Acknowledge the administrative amendment and amend the preconstruction permit or certificate; or

2. Notify the permittee that the change was not eligible for processing as an administrative amendment. In this event, a permittee shall be subject to penalties for noncompliance with the preconstruction permit or certificate during the time the change was in effect, pursuant to N.J.A.C. 7:27A.

7:27-8.15 Seven-day-notice changes

(a) A permittee may make may any of the changes at (c) below through the procedures for a seven-day-notice change set forth in this section. The Department shall attach the notice of the seven-day-notice change to the preconstruction permit. If the requirements of this section are met, a permittee may make a seven-day-notice change seven days after the Department's receipt of the notice of the change.

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(b) Any other provision of this section notwithstanding, no change may be made pursuant to this section if the change would:

1. Require an increase in any emissions limit established in the operating permit, including any maximum allowable emissions rate or concentration or any emissions cap;

2. Include construction, installation, or alteration of equipment or control apparatus; or would include replacement of equipment or control apparatus, or of any substantial component thereof, except as provided in (c)2, 3 or 11 below;

3. Change a monitoring, recordkeeping, or reporting requirement set forth in the preconstruction permit or certificate, if the changed requirement would be inconsistent with, or less stringent than, the existing requirement; or

4. Be made at a facility subject to operating permit requirements pursuant to N.J.A.C. 7:27-22, and would constitute a significant modification pursuant to N.J.A.C. 7:27-22.24, or modification under any provision of Title I of the CAA.

(c) Except as prohibited at (b) above, any of the following changes may be made as a seven-day-notice change, pursuant to the procedures of this section:

1. A change in the contents of a storage tank, bin, silo or other storage container, for which a preconstruction permit and certificate are in effect, provided such change does not:

i. Involve the use or storage of any HAP; or

ii. Cause the storage tank to become, pursuant to N.J.A.C. 7:27-16.2(b), subject to any control requirement to which the storage tank was not previously subject;

2. Replacement of any equipment or control apparatus which is not a substantial component as defined at N.J.A.C. 7:27-8.1, provided that:

i. The replacement equipment or control apparatus operates on the same physical or chemical principle as that which is being replaced;

ii. The replacement equipment or control apparatus is equivalent to, or better than, for the purpose of air pollution control, that which is being replaced;

iii. A preconstruction permit or operating permit is in effect for the equipment or control apparatus; and

iv. The date of approval of the preconstruction permit authorizing the installation of the equipment or control apparatus being replaced is less than five years prior to the date of installation of the replacement equipment or control apparatus;

3. Replacement of any equipment or control apparatus which is a substantial component as defined at N.J.A.C. 7:27-8.1, provided that:

i. The replacement is authorized in the preconstruction permit or certificate;

ii. The replacement is made in accordance with a schedule included in the preconstruction permit or certificate or is identified in the permit or certificate as a spare component kept on site for replacement purposes; and

iii. The component being replaced was installed less than five years previous to the replacement;

4. Any of the following changes to a stack or chimney or the use thereof, provided that the change is in compliance with EPA stack height regulations promulgated at 40 CFR 51:

i. A change in the number of stacks or chimneys serving the equipment or control apparatus, provided that the change does not result in any discharge height lower than that of the tallest stack or chimney existing prior to the change;

ii. A decrease in the diameter of a stack or chimney, provided that the exhaust is vented upward;

iii. The replacement of an existing stack or chimney with a taller stack or chimney, provided that this results in an effective stack height which is no less than that existing before the change; or

iv. An increase in the exit temperature or volume of gas emitted from a stack or chimney;

5. Any reconfiguration to an alternate operating scenario, including to an alternate configuration or a change in the production process, not authorized in the preconstruction permit or certificate in effect, provided that the notice to the Department of the change contains the information required at N.J.A.C. 7:27-22.27 and that the alternate operating scenario conforms with the requirements of that section;

6. Addition, replacement, or removal of auxiliary devices or appurtenances serving equipment or control apparatus;

7. A change in the relative use, expressed in percent by weight, of any raw material in the operation of equipment or control apparatus or in the process, including the introduction of a raw material not authorized in the preconstruction permit or certificate permit in effect;

8. A decrease in the maximum allowable rate of emission of any air contaminant or category of air contaminant based on operational change, provided that the decrease does not entail any physical change made to equipment or control apparatus;

9. A modification of an authorization for intra-facility emissions trading included in a preconstruction permit, consistent with the intra-facility emissions trading provisions of N.J.A.C. 7:27-22.28;

10. A change in operation, as provided for by N.J.A.C. 7:27-22.28, which implements intra-facility emissions trading not expressly allowed by the preconstruction permit or certificate, provided that:

i. The intra-facility emissions trading is conducted pursuant to the following provisions of this chapter allowing such emissions trading:

(1) The mathematical combination provisions of N.J.A.C. 7:27-9.2(d);

(2) The emissions averaging provisions of proposed N.J.A.C. 7:27-19.6; or

(3) Any emissions averaging provisions of this chapter that expressly allow the averaging to be incorporated into a preconstruction permit or certificate pursuant to this section;

ii. The intra-facility emissions trading is approved through a preconstruction permit issued by the Department pursuant to N.J.A.C. 7:27-8.; and

iii. The permittee conforms with the intra-facility emissions trading provisions set forth at N.J.A.C. 7:27-22.28;

11. Alteration of equipment or control apparatus, or installation of new equipment or control apparatus, provided that;

i. The equipment or control apparatus are at a facility with an approved facility-wide permit, as defined at N.J.A.C. 7:27-8.1; and

ii. The alteration or installation meets the criteria for an exemption for facilities with a facility-wide permit set forth at N.J.A.C. 7:27-8.17; or

12. Relocation of a temporary facility to a site not specifically authorized in the preconstruction permit or operating certificate, unless:

i. Air quality simulation or risk assessment is required pursuant to N.J.A.C. 7:27-22.8(d); and

ii. The operating certificate specifies that an alteration is required for the relocation.

(d) A permittee shall, pursuant to (e) and (f) below, submit a timely and administratively complete notice for any change being made, pursuant to this section as a seven-day-notice change. No permittee may make a change at a facility pursuant to this section unless the written notice of the change is administratively complete and is received by the Department at least seven days before the change is made;

(e) To be deemed timely, a notice shall be submitted to the Department at least seven days prior to the change being made at the facility.

(f) To be deemed administratively complete, the notice shall include all information required by the form of notice obtained from the Department, which form shall require the following information:

1. A description of the planned change, and a statement of the reason the change is being made;

2. The date(s) or schedule for when the change will be made, or a description of the types of circumstances under which the change would be made;

3. The specific source operations that will be changed or will be affected by the change;

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4. For each source operation given in (f)3 above, each air contaminant for which the quantity or rate of actual emissions would be increased or decreased as a result of the change, and the quantity of that increase or decrease, including any new air contaminant which may be emitted as a result of the change;

5. Specification of any permit requirement or applicable requirement that will be:

i. Complied with through the change; or

ii. No longer applicable as a result of the change;

6. A statement affirming that the facility will comply with all preconstruction permits and certificates issued for the facility;

7. Certification of the notice of the change in accordance with N.J.A.C. 7:27-1.39; and

8. Any other information that is reasonably necessary to enable the Department to determine whether the notice satisfies the requirements of this section.

(g) For a facility with an approved facility-wide permit, making a change pursuant to (c)11 above, an administratively complete notice shall include, in addition to the information required at (f) above, a Pollution Prevention Plan Modification or Pollution Prevention Assessment pursuant to N.J.A.C. 7:1K-3 and 4.

(h) If the notice is not received by the Department at least seven days prior to the change, the permittee shall be liable for penalties for each day between the day the change was made, and the seventh day after the Department's receipt of the notice.

(i) Upon receipt of a notice of a seven-day-notice change, the Department will issue an acknowledgement of receipt of the notice, and file the notice as an attachment to the preconstruction permit or certificate. Such acknowledgement does not constitute approval by the Department of the change as a seven-day-notice change.

(j) If the Department subsequently determines that the change filed with a preconstruction permit or certificate pursuant to (i) above is not eligible for processing through seven-day-notice change procedures, the permittee shall be subject to penalties for noncompliance with the preconstruction permit or certificate, pursuant to N.J.A.C. 7:27A-3, for each day during which the change was in operation. The Department's failure to notify a permittee that a change is not eligible for processing as a seven-day-notice change shall not be a defense to liability for such penalties.

(k) The permittee shall attach a copy of each notice submitted pursuant to this section to the copy of the preconstruction permit or certificate the permittee maintains at the facility.

(l) A permittee may elect to make as an alteration, any change authorized to be made as a seven-day-notice change.

7:27-8.16 Alterations

(a) A permittee may make any change given at (b) below through the procedures for alterations set forth in this section.

(b) A change shall be made as an alteration pursuant to this section, if the change is:

1. A change in the location of the point of discharge of any air contaminant from equipment or control apparatus into the outdoor atmosphere, unless the change is authorized in the preconstruction permit or certificate in effect;

2. Replacement of equipment or control apparatus or of any substantial component thereof if:

i. The replacement equipment or control apparatus does not operate on the same physical or chemical principle as that which is being replaced;

ii. The replacement equipment or control apparatus is not equivalent to, or better than, for the purpose of air pollution control, that which is being replaced;

iii. The equipment or control apparatus is a substantial component, as defined at N.J.A.C. 7:27-8.1;

iv. No preconstruction permit or operating permit is in effect for the equipment or control apparatus; or

v. The date of approval of the preconstruction permit authorizing the installation of the equipment or control apparatus being replaced is more than five years prior to the date of installation of the replacement equipment or control apparatus;

3. The introduction of any new raw material to equipment or control apparatus for which no certificate or operating permit is in effect, including the change of contents of a storage tank for which no certificate is in effect;

4. Any of the following changes to equipment or control apparatus, or to the use thereof, if the change may increase the concentration or rate of any air contaminant emission:

i. Addition, replacement, or removal of auxiliary devices or appurtenances;

ii. Change in the relative use, expressed in percent by weight, of any raw material in the operation of equipment or control apparatus or in the process, including the introduction of a raw material not authorized in the preconstruction permit or certificate or operating permit in effect; or

iii. Change in the production process in which the equipment or control apparatus is used;

5. Increase in the concentration or rate of emission of any air contaminant above that authorized by the preconstruction permit or certificate, or operating permit, in effect, including an increase in any maximum allowable emissions rate or concentration or any emissions cap;

6. Emission of any air contaminant not authorized by the preconstruction permit or certificate in effect;

7. Any change to a stack or chimney or the use thereof, including any change to a stack dispersion parameter including, but not limited to, temperature, velocity, direction, or volumetric flow rate, if:

i. The change is not in compliance with EPA stack height regulations promulgated at 40 CFR 51; or

ii. The change may result in an increase in the ambient concentration of any air contaminant;

8. Any change in the concentration of any air contaminant in the influent to existing control apparatus above that authorized in the preconstruction permit or certificate, or operating permit, in effect;

9. Any increase in the total hours of operation per time period or the rate of production above that authorized in the preconstruction permit or certificate, or operating permit, in effect;

10. Any change to equipment or control apparatus, or to the use thereof, if the change will result in a contravention of any State or Federal ambient air quality standard, any provision of this chapter, or any condition or approval of any preconstruction permit or certificate in effect.

11. A change which causes the facility to be subject to, or which would constitute a modification pursuant to, any of the following:

i. Emission offset requirements pursuant to N.J.A.C. 7:27-18.2(a) and (b);

ii. NSPS regulations at 40 CFR 60;

iii. NESHAPS regulations at 40 CFR 63;

iv. PSD regulations at 40 CFR 52; or

v. Federal visibility regulations promulgated pursuant to 42 USC §7491 or 7492;

12. A change which relaxes any monitoring, recordkeeping or reporting required by the preconstruction permit or certificate;

13. A change which requires a case-by-case determination of an emission limitation or other standard contained in a State or Federal rule. This includes, for example, an application for a variance from a specific emission limit;

14. A relocation of a temporary facility to a site, other than is authorized in the preconstruction permit or certificate;

15. A change which establishes or changes a permit condition for which there is no corresponding underlying applicable requirement, and which the facility has assumed to avoid an applicable requirement to which the facility would otherwise be subject. Such conditions include:

i. A Federally enforceable emissions cap assumed to avoid classification as a major facility or to avoid becoming subject to:

(1) Emission offset requirements pursuant to N.J.A.C. 7:27-18.2;

(2) NSPS regulations at 40 CFR 60;

(3) NESHAPS regulations at 40 CFR 63;

(4) PSD regulations at 40 CFR 52; or

(5) Federal visibility regulations promulgated pursuant to 42 USC §7491 or 7492; or

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ii. An alternative emissions limit for early reductions of HAPs approved pursuant to regulations promulgated under 42 U.S.C. §7412(i)(5); or

16. Any incorporation into the operating permit of a new alternative operating scenario or a new authorization for intra-facility emissions trading, not authorized by the existing preconstruction permit or certificate; or

17. Any change which is eligible to be processed as an administrative amendment or a seven-day-notice change pursuant to N.J.A.C. 7:27-8.14 or 8.15, respectively.

(c) No person may make any change which is an alteration pursuant to (b) above until the Department approves the application for an alteration.

(d) An application for an alteration shall be submitted to the Department on forms available from the Department at the address in N.J.A.C. 7:27-8.4(a). Those forms shall require the provision of all the information required for an initial application at N.J.A.C. 7:27-8.4, except that the form for an application for an alteration shall require only such information as is relevant to the proposed alteration.

(e) At a facility for which an operating permit is in effect pursuant to N.J.A.C. 7:27-22, an application for an alteration shall be submitted simultaneously with the application for a minor modification or significant modification for the proposed change, required pursuant to N.J.A.C. 7:27-22. The Department will initiate the review of both applications simultaneously. However, the application for a minor modification or significant modification shall not be deemed administratively complete until the Department approves the application for the preconstruction permit; and the time periods for Department action on an administratively complete application for a minor modification or significant modification, set forth at N.J.A.C. 7:27-22.23 and N.J.A.C. 7:27-22.24, respectively, shall not begin until the preconstruction permit is approved. If the Department denies the preconstruction permit, the minor modification or significant modification shall also be denied.

Agency Note: N.J.A.C. 7:27-8.27 is recodified below, with revisions, as N.J.A.C. 7:27-8.17.

7:27-8.17 Exemption for facilities subject to the Pollution Prevention Act

(a) A person is not required to obtain a preconstruction permit or a certificate for an alteration of equipment or control apparatus, or installation of new equipment or control apparatus, if:

1. The production process using the equipment or control apparatus, is identified in and subject to an approved facility-wide permit issued under N.J.S.A. 13:1D-35 et seq.;

2. The alteration or installation is either:

i. Allowed under the facility-wide permit; or

ii. Documented in a modification to a Pollution Prevention Plan, which satisfies the requirements of N.J.A.C. 7:1K-3 and 4, or in a Pollution Prevention Assessment as defined in N.J.A.C. 7:1K-1.5; and

3. The alteration or installation does not cause any of the following:

i. An increase in the generation of nonproduct output per unit of production manufactured by the equipment or production process;

ii. An exceedance of the maximum allowable concentration or rate of emission of any air contaminant for the production process or the entire facility, whichever is more stringent;

iii. An exceedance of the maximum allowable concentration or effluent limitation of any discharge to waters of the State; or

iv. The addition of a new production process.

(b) Any person who is exempted pursuant to (a) above from obtaining a preconstruction permit or certificate shall:

1. Notify the Department of the alteration or installation pursuant to the procedures for a seven-day-notice change at N.J.A.C. 7:27-8.15; and

2. Submit to the Department, together with the notice given pursuant to (b)1 above, documentation of the alteration or installation in the Pollution Prevention Plan Modification or Pollution Prevention Assessment, required pursuant to (a)2ii above.

7:27-8.24 [Certification of information] **(Reserved)**

[(a) Any person who submits an application, registration, or report to the Department shall include, as an integral part of the application, registration or report, the following certification, signed by the highest ranking individual with direct knowledge and overall responsibility for the information contained in the certified documents:

"I certify under penalty of law that the information provided in this document is true, accurate and complete. I am aware that there are significant civil and criminal penalties, including fines or imprisonment or both, for submitting false, inaccurate or incomplete information."

(b) The following documents shall be additionally certified as set forth in (c) and (d) below:

1. Any permit application, which is subject to any PSD requirement or to N.J.A.C. 7:27-18.2 of the emission offset rule; or

2. Any report which indicates that a violation has or may have occurred of any provision or condition of a permit or certificate or any applicable law, regulation, or rule.

(c) Any person who submits an application or report to the Department, for which additional certification is required pursuant to (b) above, shall include, as an integral part of the application or report, the following additional certification:

"I certify under penalty of law that I have personally examined and am familiar with the information submitted in this application and all attached documents and, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete. I am aware that there are significant civil and criminal penalties, including the possibility of fine or imprisonment or both, for submitting false, inaccurate or incomplete information."

(d) The additional certification set forth in (c) above shall be signed by the ranking official, as follows:

1. For a corporation, a principal executive officer of at least the level of vice president;

2. For a partnership or sole proprietorship, a general partner or the proprietor, respectively;

3. For a municipality, the mayor or equivalent official;

4. For a county, the county executive or equivalent official;

5. For the State, an official of at least the rank of agency director; or

6. For any other public agency, a principal executive officer or ranking elected official.

(e) Notwithstanding the provisions of (b) above, the certification contained in (a) above shall be the only certification required if the individual required in (a) above to sign the certification is the same individual required in (d) above to sign the additional certification.]

7:27-8.25 [Inspections] **(Reserved)**

[(a) The Department and its representatives shall have the right to enter and inspect any facility, building or equipment, or any portion thereof, at any time, in order to ascertain compliance or non-compliance with the Air Pollution Control Act, N.J.S.A. 26:2C, this chapter, any permit or any certificate, or any order or agreement issued or entered into pursuant thereto. The Department and its representatives shall also have the right to enter and inspect any facility, building or equipment, or any portion thereof, at any time to verify any information included in any application or report submitted to the Department. Such right shall include, but not be limited to, the right to test or sample any materials at the facility, to sketch or photograph any portion of the facility, building or equipment, to copy or photograph any document or records necessary to determine such compliance or non-compliance, and to interview any employees or representatives of the owner, operator or registrant. Such right shall be absolute and shall not be conditioned upon any action by the Department, except the presentation of appropriate credentials as requested and compliance with appropriate standard safety procedures.

(b) Owners or operators, and any employees or representatives thereof, shall assist and shall not hinder or delay the Department and its representatives in the performance of all aspects of any inspection. Such assistance shall include making available sampling

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equipment necessary to conduct sampling at the facility and providing sampling facilities for the Department to determine the nature and quantity of any air contaminant emitted. During such testing by the Department, the equipment and all components connected, attached to, or serving the equipment shall be used and operated under normal routine operating conditions or under such other conditions, consistent with the operational parameters and limits set forth in the permit or certificate in effect, as may be requested by the Department. The facilities may be either permanent or temporary, at the discretion of the person responsible for their provision, and shall conform to all applicable laws and regulations concerning safe construction and safe practice.

(c) No person shall obstruct, hinder or delay, or interfere with by force or otherwise, the performance by the Department or its personnel of any duty under the provisions of this chapter, or refuse to permit such personnel to perform their duties by refusing them upon proper identification or presentation of a written order of the Department, entrance to any premises at reasonable hours.]

[7:27-8.27 Exemption for Pollution Prevention Alterations at Facilities Subject to N.J.S.A. 13:1D-35 et seq.

(a) A person is not required to obtain a permit or a certificate for an alteration of equipment or control apparatus, or installation of new equipment or control apparatus, if:

1. The production process using the equipment or control apparatus, is identified in and subject to an approved facility-wide permit issued under N.J.S.A. 13:1D-35 et seq.;

2. The alteration or installation is either:

i. Allowed under the facility-wide permit; or

ii. Documented in a modification to a Pollution Prevention Plan, which satisfies the requirements of N.J.A.C. 7:1K-3 and 4, or in a Pollution Prevention Assessment as defined in N.J.A.C. 7:1K-1.5; and

3. The alteration or installation does not cause any of the following:

i. An increase in the generation of nonproduct output per unit of production manufactured by the equipment or production process;

ii. An exceedance of the maximum allowable concentration or rate of emission of any air contaminant for the production process or the entire facility, whichever is more stringent;

iii. An exceedance of the maximum allowable concentration or effluent limitation of any discharge to waters of the State; or

iv. The addition of a new production process.

(b) Any person who is exempted pursuant to (a) above from obtaining a permit and certificate shall report the alteration or change and the Pollution Prevention Plan Modification or Pollution Prevention Assessment to the Department within 120 days after the occurrence of the alteration or change, as an amendment of the facility-wide permit pursuant to the procedures for amendment at N.J.A.C. 7:27-8.3(c).

(c) For equipment or control apparatus subject to (a) above, the facility wide permit shall constitute the operating certificate required by this chapter.]

APPENDIX I

TABLE A
HAZARDOUS AIR POLLUTANTS

Chemical	CAS Number
Acrolein	107028
Acrylamide	79061
Asbestos	1332214
Beryllium compounds	—
1,3-Butadiene	106990
Cadmium compounds	—
Chlordane	57745
2-Chloroacetophenone	532274
1,2-Dibromo-3-cholorpropane	96128
Dichloroethyl ether (Bis(2-chloroethyl)ether)	111444
1,2-Dyphenylhydrazine	122667
Heptachlor	76448
Hexachlorobenzene	118741
Hexamethylene-1.6-diisocyanate	822060
Lead compounds	—
Lindane (all isomers)	58899
Mercury compounds	—
Nickel compounds	—
Polychlorinated biphenyls (Arochlors)	1336363
1,1,2,2,-Tetrachloroethane	79345
Toxaphene (chlorinated camphene)	8001352

TABLE B
HAZARDOUS AIR POLLUTANTS

Chemical	CAS Number
Acrylic acid	79107
Acrylonitrile	107131
Benzene	71432
Benzyl chloride	100447
Carbon tetrachloride	56235
Chloroform	67663
1.4-Dioxane (1.4-Diethyleneoxide)	123911
Ethylene dibromide (Dibromoethane)	106934
Ethylene dichloride (1.2-Dichloroethane)	107062
Ethylene oxide	75218
Formaldehyde	50000
Hexachlorobutadiene	87683
Hexachlorocyclopentadiene	77474
Hexachloroethane	67721
Methylene diphenyl diisocyanate (MDI)	101688
Tetrachloroethylene (Perchloroethylene)	127184
1,1,2-Trichloroethane	79005
Trichloroethylene	79016
2,4,6-Trichlorophenol	88062
Vinyl bromide	593602
Vinyl chloride	75014
Vinylidene chloride (1,1-Dicholoroethylene)	75354

TABLE C
Thresholds for De Minimis Emissions Of Hazardous Air Pollutants

Air Contaminant	Annual emissions pounds per year
Total dioxin and furans	0.0001
Benzidine	0.06
Bis (chloromethyl) ether	0.06
n-Nitrosodimethylamine	0.2
Hexavalent chromium compounds	0.4
Hydrazine	0.8
Arsenic and arsenic compounds	1.0
2-Nitropropane	1.0
Any Table A HAP (1)	2.0
Any Table B HAP (2)	20.0
Any other HAP	400.0

(1) This air contaminant category shall apply to any HAP listed in Table A at N.J.A.C. 7:27-8, Appendix I.

(2) This air contaminant category shall apply to any HAP listed in Table B at N.J.A.C. 7:27-8, Appendix I.

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TABLE D
Thresholds for De Minimis Emissions
Of Other Air Contaminants

Air Contaminant	Annual emissions (pounds per hour)
VOC	0.05
TSP	0.05
PM-10	0.05
NOx	0.05
CO	0.05
SO2	0.05
Any other air contaminant (1)	0.05

(1) This air contaminant category shall apply to any other air contaminant that the facility has the potential to emit in a quantity greater than or equal to 100 tons per year.

7:27-18.1 Definitions

The following words and terms, when used in this subchapter, [shall] have the following meanings, unless the context clearly indicates otherwise.

. . .

["Permit" means a "Permit to Construct, Install, or Alter Control Apparatus or Equipment" as required in accordance with the provisions of the Air Pollution Control Act (N.J.S.A. 26:2C-1 et seq.) and in particular N.J.S.A. 26:2C-9.2, and N.J.A.C. 7:27-8.]

. . .

"Preconstruction permit" means a "Permit to Construct, Install, or Alter Control Apparatus or Equipment" issued by the Department pursuant to the Air Pollution Control Act of 1954, specifically N.J.S.A. 26:2C-9.2.

. . .

SUBCHAPTER 22. OPERATIVE PERMITS

7:27-22.1 Definitions

Words and terms, when used in this subchapter, have the meanings given below unless defined at N.J.A.C. 7:27-1.4 or the context clearly indicates otherwise.

"Accountable" means, in respect to compliance with an emissions limit, verifiable through the keeping, maintenance, and accessibility of clear, appropriately comprehensive, and reliable records.

"Actual emissions" means the rate at which an air contaminant is actually emitted, either directly or indirectly, to the outdoor atmosphere, in units of mass per calendar year, seasonal period, or other time period specified by the Department.

"Administrative amendment" means the type of change made at a facility, and incorporated into an operating permit, through the procedures for administrative amendments at N.J.A.C. 7:27-22.20.

"Administratively complete application" means an application which includes sufficient information for the Department to commence review of the application. This information shall include all of the information required by this subchapter for the type of application being submitted, submitted on or with forms obtained from the Department and in accordance with the instructions accompanying the application forms. To be complete, an application shall include all preconstruction permits issued for the facility as of the date of the operating permit application. An application which is administratively complete may require supplementary information in order for the Department to take final action on the application.

"Affected state" means, in respect to an application for an operating permit, operating permit renewal, minor modification, or significant modification, any state in the United States that:

1. Is contiguous to New Jersey; or

2. Is located within 50 miles of the facility which is the subject of the application.

"Affected Title IV facility" means a facility that includes one or more "affected units," as that term is defined in the acid deposition control provisions of Title IV the CAA, 42 U.S.C. §7651 et seq. This term has the same meaning as the term "affected source" as defined in 40 CFR 70.

"Affected Title IV unit" has the meaning given to it in the regulations promulgated by EPA under the acid deposition control program, set forth at Title IV of the CAA.

"Air contaminant" means any substance, other than water or distillates of air, present in the atmosphere as solid particles, liquid particles, vapors or gases.

"Air quality simulation model" means a mathematical procedure, taking into account the dispersive capacity of the atmosphere and other relevant factors, to predict the concentration of an air contaminant in the ambient air.

"Allowance" means an authorization granted to an affected Title IV unit by the EPA under acid deposition control requirements at Title IV of the CAA. The authorization allows the unit to emit one ton of SO_2 during or after a specified calendar year.

"Alteration" has the meaning assigned to this term at N.J.A.C. 7:27-8.1.

"Alternative operating scenario" means a plan for operating a facility or a portion thereof in a way, or according to a method, or using methods or processes, which are different from other methods or processes used at the facility, or portion thereof.

"Applicable Federal requirement" means any of the following standards, provisions or requirements as they apply to any source operation in a facility which is subject to this subchapter. Applicable requirements include requirements that have been promulgated or approved by EPA through rulemaking but have future-effective compliance dates:

1. Any standard or other requirement provided for in New Jersey's approved SIP (or FIP, if applicable), including any approved revisions;

2. Any provision or condition of any preconstruction permit issued pursuant to N.J.A.C. 7:27-8, except for any prohibition of nuisance odors pursuant to N.J.A.C. 7:27-8.8(f);

3. Any NSPS or other standard or requirement under 42 U.S.C. §7411 including 42 U.S.C. §7411(d);

4. Any standard or other requirement concerning HAPs under 42 U.S.C. §7412, including any requirement concerning accident prevention under 42 U.S.C. §7412(r)(7);

5. Any standard or other requirement of the acid deposition control program under Title IV of the CAA or the regulations promulgated thereunder;

6. Any requirement established pursuant to the provisions for monitoring in Title V of the CAA at 42 U.S.C. §7661c(b) or pursuant to the monitoring requirements at 42 U.S.C. §7414(a)(3);

7. Any standard or other requirement governing solid waste incineration under 42 U.S.C. §7429;

8. Any standard or other requirement for consumer and commercial products under 42 U.S.C. §7511b(e);

9. Any standard or other requirement for marine tank vessels under 42 U.S.C. §7511b(f);

10. Any standard or other requirement of the program to prevent or control the emission of air contaminants from outer continental shelf sources under 42 U.S.C. §7627;

11. Any standard or other requirement of the regulations promulgated to protect stratospheric ozone under Title VI of the CAA, unless EPA has determined that such a requirement need not be contained in an operating permit;

12. Any of the following, but only as it would apply to temporary facilities permitted pursuant to 42 U.S.C. §7661c(e):

i. A NAAQS; or

ii. An increment under 42 U.S.C. §7473; or

iii. A visibility requirement under 42 U.S.C. §7491 or 7492.

"Applicable requirement" means any applicable State requirement or applicable Federal requirement.

"Applicable State requirement" means any provision, standard or requirement in any statute or rule, as it applies to a facility or source operation which is subject to this subchapter, except an applicable Federal requirement. This term includes requirements that have been promulgated by the Department and submitted to EPA as SIP revisions but have not yet been approved by EPA.

"Applicable VOC" means any VOC which has a vapor pressure or sum of partial pressures of organic substances of 0.02 pounds

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per square inch (1.0 millimeters of mercury) absolute or greater at standard conditions.

"Application shield" means the protection from enforcement action set forth at N.J.A.C. 7:27-22.6.

"Area source" means, in respect to GACT standards, any stationary source of hazardous air pollutant that is not a major HAP facility.

"Attainment area" means any area of the State which is not a nonattainment area.

"BACT" or "best achievable control technology" has the meaning set forth for this term in the PSD regulations at 40 CFR 52.

"CFR" means the United States Code of Federal Regulations.

"Carbon monoxide" or "CO" means a gas having a molecular composition of one carbon atom and one oxygen atom.

"Chemical Abstract Service number" or "CAS number" means a number assigned to a chemical by the American Chemical Society's Chemical Abstract Service Registry.

"Class I substance" means an air contaminant that is listed in 42 U.S.C. §7671a(a), or promulgated by EPA in a Federal rule, as a substance that has been found to cause or contribute significantly to harmful effects on the stratospheric ozone layer.

"Class II substance" means an air contaminant that is listed in 42 U.S.C. §7671a(b), or promulgated by EPA in a Federal rule, as a substance that is known or may reasonably be anticipated to cause or contribute to harmful effects on the stratospheric ozone layer.

"Clean Air Act" or "CAA" means the Federal Clean Air Act, 42 U.S.C. §7401 et seq., and subsequent amendments thereto.

"Commercial fuel" means solid, liquid, or gaseous fuel normally produced or manufactured, and sold for the purpose of creating useful heat.

"Compliance plan" means a plan meeting the requirements of N.J.A.C. 7:27-22.9, which is developed and submitted as part of an application for an operating permit, renewal, or significant modification.

"Compliance schedule" means the portion of a compliance plan which fulfills the requirements of N.J.A.C. 7:27-22.8(c)7ii.

"Construction of a major HAP facility" means, when used at N.J.A.C. 7:27-22.26, the fabrication (on site), erection, or installation of a new major HAP facility, or the fabrication (on site), erection, or installation of a new source operation at an existing facility if the new construction in and of itself constitutes a major HAP facility.

"Consumer Price Index" or "CPI" means, for any calendar year, the annual average Consumer Price Index for all-urban consumers published by the United States Department of Labor.

"Continuous data recorder" means a mechanism which continuously records the information gathered by a CEM, CPM, COM, or other continuous measurement device.

"Continuous emissions monitor" or "CEM" means a device which continuously measures the emissions from one or more source operations.

"Continuous monitoring system" or "CMS" means a system designed to continuously measure various parameters at a facility which may affect or relate to a facility's emissions. Components of a CMS include, but are not limited to, any continuous emissions monitor (CEM), continuous opacity monitor (COM), continuous process monitor (CPM), or any other constantly operating measuring device and recording device approved by the Department to perform one or more of the functions of a CMS. Ambient monitors, which measure the impact or concentration of air contaminants emitted by the source operation or facility in nearby areas, are not considered part of a facility's CMS.

"Continuous opacity monitor" or "COM" means a device which continuously measures opacity of flue gases on a continuing basis.

"Continuous process monitor" or "CPM" means an instrument or system which continuously measures an operational parameter at a facility, such as temperature or air flow rate.

"Control apparatus" means any device which prevents or controls the emission of any air contaminant directly or indirectly into the outdoor atmosphere.

"Co-product" means one or more incidental results of a production process that is not a primary product of the production process and that is sold in trade in the channels of commerce to the general public in the same form as it is produced, for any purpose except the purpose of energy recovery. A co-product is not considered nonproduct output. Increases in quantities of co-products do not count towards use reduction or nonproduct output reduction goals. This term shall have the same meaning as defined for the term "co-product" at N.J.A.C. 7:1K-1.5; if there is any conflict between the definition at N.J.A.C. 7:1K-1.5 and this one, the definition at N.J.A.C. 7:1K-5 shall control.

"Criteria pollutant" means any air contaminant for which a NAAQS has been promulgated under 40 CFR 50 or for which a NJAAQS has been promulgated at N.J.A.C. 7:27-13.

"De minimis" means, in respect to the emission of air contaminants, the quantity of any air contaminant which does not exceed the applicable de minimis emissions level set forth in Table A or Table B at N.J.A.C. 7:27-22.6.

"Designated Title IV representative" means a responsible official authorized, through the submission to the Department of a certificate of designation, to represent the owner or operator of an affected Title IV unit for purposes of acid deposition control program operating permit requirements, in matters pertaining to the holding, transfer, or disposition of allowances allocated to the affected Title IV unit, and the submission of operating permit applications and compliance with operating permits, and compliance plans for the affected Title IV unit.

"Development" means investigations in a laboratory or pilot plant directed toward the structuring or establishment of methods of manufacture or of specific designs of salable substances, devices or procedures, based upon previously discovered facts, scientific principles or substances. Development shall not include production for sale of established products through established processes; nor shall it include production in plant, works or semi-works equipment for distribution through marketing-testing channels.

"DOT" means the New Jersey Department of Transportation.

"Draft operating permit" means the version of an operating permit which is developed by the Department pursuant to after the Department's receipt of an administratively complete application, and released for public comment and an opportunity for a public hearing pursuant to N.J.A.C. 7:27-22.11. After receiving and considering the comments on the draft operating permit, the Department will develop a proposed operating permit for submittal to EPA for approval prior to issuing a final operating permit.

"Emergency" means any situation arising from sudden and reasonably unforeseeable events beyond the control of a facility, such as an act of God, which requires immediate corrective action to restore normal operation, and which causes the facility, due to unavoidable increases in emissions attributable to the emergency to exceed a technology-based emission limitation set forth in its operating permit. This term shall not include noncompliance caused by improperly designed equipment, lack of preventive maintenance, careless or improper operation, or operator error.

"Emissions" means any release of any air contaminant directly or indirectly into the atmosphere.

"Emissions cap" means an emissions limit, or limits, established in a permit for a group of source operations, which establishes the maximum quantity of emissions which may be released, in the aggregate, from a specified group of source operations.

"Enforceable" means, in respect to an emissions limit, based on sufficient statutory and regulatory authority to be recognized in a court of law.

"Equipment" means any device capable of causing the emission of an air contaminant either directly or indirectly to the outdoor atmosphere, and any stack or chimney, conduit, flue, duct, vent or similar device connected or attached to, or serving the equipment. This term includes, but is not limited to, a device in which the preponderance of the air contaminants emitted is caused by a manufacturing process.

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"Exempt activity" means any activity which is identified as an exempt activity pursuant to the requirements for application contents at N.J.A.C. 7:27-22.5.

"Existing facility" means a facility which is in operation as of the applicable date of the provision for which this term is being used.

"Facility" means the combination of all structures, buildings, equipment, storage tanks, source operations, and other operations located on one or more contiguous or adjacent properties, which are under common control of the same person or persons.

"Facility-wide permit" means a single permit issued by the Department to the owner or operator of a priority industrial facility incorporating the permits, certificates, registrations, or any other relevant Department approvals previously issued to the owner or operator of the priority industrial facility pursuant to the Solid Waste Management Act, N.J.S.A. 13:1E-1 et seq., the Water Pollution Control Act, N.J.S.A. 58:10A-1 et seq., the Air Pollution Control Act, N.J.S.A. 26:2C-1 et seq., and the appropriate provisions of the Pollution Prevention Plan prepared by the owner or operator of the priority industrial facility pursuant to N.J.S.A. 13:1D-41 and 42. This term shall have the same meaning as defined for the term "facility-wide permit" at N.J.A.C. 7:1K-1.5; if there is any conflict between the definition at N.J.A.C. 7:1K-1.5 and this one, the definition at N.J.A.C. 7:1K-1.5 shall control.

"Federally enforceable" means any limitation or condition on operation, production, or emissions that can be enforced by EPA. These limitations and conditions that can be enforced by EPA include, but are not limited to, those established pursuant to:

1. Any standard of performance for new stationary sources (NSPS) promulgated at 40 CFR 60;

2. Any national emission standard for hazardous air pollutants (NESHAP) promulgated at 40 CFR 61;

3. Any provision of an applicable SIP;

4. Any permit issued pursuant to requirements established at 40 CFR 51, Subpart I; 40 CFR 52.21; 40 CFR 70; 40 CFR 71; or

5. Any permit or order issued pursuant to requirements established under the Air Pollution Control Act, N.J.S.A. 26:2C-1 et seq., or this chapter, except to the extent that the permit or order prohibits certain odors pursuant to N.J.A.C. 7:27-8.8(f) or N.J.A.C. 7:27-5.

"Federal Implementation Plan (FIP)" means a plan, or portion thereof, promulgated by EPA pursuant to the CAA to address or otherwise correct all or a portion of an inadequacy in a SIP.

"Final operating permit" means the version of an operating permit issued by the Department after completion of the procedures required by this subchapter for a draft operating permit and a proposed operating permit.

"Fugitive emissions" means any air contaminant emissions released directly or indirectly into the outdoor atmosphere which can not reasonably pass through a stack or chimney.

"GACT standard" or "Generally Available Control Technology standard" means a National Emission Standard for a Hazardous Air Pollutant (NESHAP) establishing an emission limitation for a specific category or subcategory of area sources that emit hazardous air pollutants (HAPs), which NESHAP has been promulgated by EPA pursuant to 42 U.S.C. §7412.

"General operating permit" means a standardized operating permit, which may be used to provide authorization to operate numerous similar source operations, groups of source operations, or facilities, each of which meets the applicability criteria set forth in the general operating permit, and is issued pursuant to the procedures in N.J.A.C. 7:27-22.24.

"Hazardous air pollutant" or "HAP" means an air contaminant listed by EPA as a HAP, pursuant to 42 U.S.C. §7412(b). That list is incorporated by reference herein, together with all amendments and supplements. A copy of the list is available from the Department at the address set forth at N.J.A.C. 7:27-22.3(t).

"Initial operating permit" means the first operating permit issued pursuant to this subchapter which applies to a particular facility, or a portion thereof.

"Insignificant source operation" means a source operation which is included in the list of insignificant source operations set forth in the application contents requirements at N.J.A.C. 7:27-22.56.

"Install" means to carry out final setup activities necessary to provide the equipment or control apparatus with the capacity for use or service. This term includes, but is not limited to, the connection of the equipment and control apparatus, associated utilities, piping, ductwork and conveyor systems. This term does not include the term "construct," as defined at N.J.A.C. 7:27-8.1, nor the reconfiguration of equipment and control apparatus to an alternate configuration specified in the permit application and approved by the Department.

"Intermediate product" means one or more desired results of a production process that is made into a product in a subsequent production process at the same industrial facility, without the need for pollution treatment prior to its being made into a product. An intermediate product is not considered nonproduct output. Increases in quantities of intermediate products do not count towards use reduction or nonproduct output reduction goals. This term shall have the same meaning as defined for the term "intermediate product" at N.J.A.C. 7:1K-1.5; if there is any conflict between the definition at N.J.A.C. 7:1K-1.5 and this one, the definition at N.J.A.C. 7:1K-1.5 shall control.

"Intra-facility emissions trading" means the averaging of emissions of a given air contaminant from two or more source operations within a facility, such that their total emissions collectively are less than a federally enforceable emissions cap.

"Lowest achievable emission rate" or "LAER" has the meaning assigned to this term at N.J.A.C. 7:27-18.1.

"Lead" or "Pb" means elemental lead or any compound containing lead measured as elemental lead.

"MACT standard" or "Maximum Achievable Control Technology standard" means a National Emission Standard for a Hazardous Air Pollutant (NESHAP) establishing an emission limitation for a specific category or subcategory of major facilities which emit one or more hazardous air pollutants (HAPs), which NESHAP is:

1. Promulgated by EPA pursuant to 42 U.S.C. §7412; or

2. Determined by the Department on a case-by-case basis pursuant to 42 U.S.C. §7412(g) or (j).

"Major facility" means a facility which has the potential to emit any of the air contaminants listed below in an amount which is equal to or exceeds the applicable major facility threshold level given below. The major facility threshold levels are as follows:

Air Contaminant	Major Facility Threshold Level
Carbon Monoxide	100 tons per year
PM-10	100 tons per year
TSP	100 tons per year
Sulfur dioxides	100 tons per year
Oxides of nitrogen	25 tons per year
VOC	25 tons per year
Lead	10 tons per year
Any HAP	10 tons per year
All HAPs, collectively	25 tons per year
Any other air contaminants	100 tons per year

Major facilities are subject to this subchapter pursuant to N.J.A.C. 7:27-22.2.

"Major Hazardous Air Pollutant (HAP) facility" means a major facility, or part thereof, which emits or has the potential to emit:

1. Ten tons or more per year of any HAP; or

2. Twenty five tons or more per year of any HAPs, collectively.

"Manufacturing process" means any action, operation, or treatment embracing chemical, industrial, manufacturing, or processing factors, methods or forms including, but not limited to, furnaces, kettles, ovens, converters, cupolas, kilns, crucibles, stills, dryers, roasters, crushers, grinders, mixers, reactors, regenerators, separators, filters, reboilers, columns, classifiers, screens, quenchers, cookers, digesters, towers, washers, scrubbers, mills, condensers, and absorbers.

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"Maximum allowable emissions" means, for the purpose of this subchapter, the maximum amount of an air contaminant allowed to be emitted, as specified in the final operating permit issued by the Department.

"Minor modification" means a change made at a permitted facility in accordance with N.J.A.C. 7:27-23.

"Modification of a major HAP facility" means, when used at N.J.A.C. 7:27-22.26, any physical change in, or change in the method of operation of, a major HAP facility, which:

1. Increases the facility's actual emissions of any HAP by more than an amount established by EPA as de minimis for that HAP at 40 CFR 63; or

2. Results in the emission of any HAP not previously emitted, in more than the amount established by EPA as de minimis for that HAP at 40 CFR 63.

"Monitoring" means to evaluate a facility's processes, operations, emissions or other aspects over a period of time. Monitoring can be accomplished using CEMs, COMs, CMS, CPMs, or other measurement or evaluation mechanisms.

"National ambient air quality standard" or "NAAQS" means an ambient air quality standard promulgated at 40 CFR 50.

"NESHAP" means a National Emission Standard for a Hazardous Air Pollutant as promulgated under 40 CFR 63.

"New Jersey ambient air quality standard" or "NJAAQS" means an ambient air quality standard promulgated at N.J.A.C. 7:27-13.

"Nonattainment area" means any area of the State:

1. Identified by the Department as one in which the ambient air concentration of a criteria pollutant exceeds a NAAQS or NJAAQS; or

2. Designated by the EPA at 40 CFR 81.331 as an area in which the ambient air concentration of a criteria pollutant exceeds the applicable NAAQS.

"Nonproduct output" or "NPO" means all hazardous substances or hazardous wastes that are generated prior to storage, out-of-process recycling, treatment, control or disposal, and that are not intended for use as a product. Nonproduct output includes fugitive releases. This term shall have the same meaning as defined for the term "nonproduct output" at N.J.A.C. 7:1K-1.5; if there is any conflict between the definition at N.J.A.C. 7:1K-1.5 and this one, the definition at N.J.A.C. 7:1K-1.5 shall control.

"NSPS" means a Standard of Performance for New Stationary Sources as promulgated under 40 CFR 60, commonly referred to as New Source Performance Standards.

"Operating certificate" means a "Certificate to Operate Control Apparatus or Equipment" issued by the Department pursuant to N.J.S.A. 26:2C-1 et seq., and in particular N.J.S.A. 26:2C-9.2, and implementing rules at N.J.A.C. 7:27-8. An operating certificate is generally issued for new or altered equipment at non major facilities for which operating permits are not required and for new or altered equipment at major facilities which are not yet required to have a final operating permit.

"Operating permit" means a permit issued by the Department pursuant to this subchapter to authorize the use of one or more source operations from which air contaminants may be emitted. This term includes a general operating permit which is applicable facility wide, but does not include a general operating permit which applies only to a part of a facility (unless the general operating permit is itself incorporated into a facility wide operating permit). This term also includes an operating permit issued for a temporary facility; for a facility, or part thereof, subject to a MACT or GACT standard pursuant to N.J.A.C. 7:27-22.26; or for a component of a facility pursuant to N.J.A.C. 7:27-22.5(i).

"Order" means any and all orders issued by the Department including, but not limited to, administrative orders and administrative consent orders.

"Oxides of nitrogen" or "NO_x" means all oxides of nitrogen, except nitrous oxide, as measured by test methods approved by the Department and EPA, such as the test methods set forth at 40 CFR 60, Appendix A, Methods 7 through 7E.

"Permittee" means, for the purpose of this subchapter, any person to whom the Department has issued an operating permit.

"Person" means any individual or entity and shall include, without limitation, corporations, companies, associations, societies, firms, partnerships and joint stock companies, and shall also include, without limitation, all political subdivisions of any State, and any agencies or instrumentalities thereof.

"Phase I" means a time period designated pursuant to the Title IV acid deposition control program as commencing November 1, 1995, and ending December 31, 1999.

"Phase II" means a time period designated pursuant to the Title IV acid deposition control program as commencing January 1, 2000, and continuing indefinitely.

"PM-10" means a class of air contaminants which includes all particulate matter having an aerodynamic diameter less than or equal to 10 micrometers.

"Pollution Prevention Assessment" means an assessment of potential pollution prevention opportunities for the use, generation and release of non-hazardous substances, prepared by an owner or operator of a priority industrial facility that is covered by an effective facility-wide permit issued by the Department, containing the same elements as those required for hazardous substances by N.J.A.C. 7:1K-4.3 and 4.5. This term shall have the same meaning as defined for the term "Pollution Prevention Assessment at N.J.A.C. 7:1K-1.5; if there is any conflict between the definition at N.J.A.C. 7:1K-1.5 and this one, the definition at N.J.A.C. 7:1K-1.5 shall control.

"Pollution Prevention Plan" means a plan required to be prepared by an industrial facility pursuant to N.J.S.A. 13:1D-41 and 42, N.J.A.C. 7:1K-3 and N.J.A.C. 7:1K-4. This term shall have the same meaning as defined for the term "Pollution Prevention Plan" at N.J.A.C. 7:1K-1.5.

"Potential to emit" means the maximum aggregate capacity of a source operation or of a facility to emit an air contaminant under its physical and operational design. Any physical or operational limitation on the capacity of a source operation or a facility to emit an air contaminant, including control apparatus, and restrictions on hours of operation or on the type or amount of material combusted, stored or processed, shall be treated as part of its design, if the limitation is Federally enforceable. Fugitive emissions shall be included in the determination of potential to emit. However, the determination shall not include any banked emission reductions that are held by the owner or operator.

"Preconstruction permit" means a "Permit to Construct, Install, or Alter Control Apparatus or Equipment" issued by the Department pursuant to N.J.S.A. 26:2C-1 et seq., in particular N.J.S.A. 26:2C-9.2, and implementing rules at N.J.A.C. 7:27-8.

"PSD" or "prevention of significant deterioration" means the permitting process, set forth at 40 CFR 52, which applies to new or modified major emitting facilities located in attainment areas. The EPA has delegated the administration of the PSD program in New Jersey to the Department.

"Product" means one or more desired results of a production process that is used as a commodity in trade in the channels of commerce by the general public in the same form as it is produced. Products include intermediate products transferred to a separate industrial facility owned or operated by the same owner or operator. This term shall have the same meaning as defined for the term "product" at N.J.A.C. 7:1K-1.5; if there is any conflict between the definition at N.J.A.C. 7:1K-1.5 and this one, the definition at N.J.A.C. 7:1K-1.5 shall control.

"Production process" means a process, line, method, activity or technique, or a series or combination of processes, lines, method or techniques, used to produce a product or reach a planned result. This term shall have the same meaning as defined for the term "production process" at N.J.A.C. 7:1K-1.5.

"Proposed operating permit" means the version of an operating permit which is developed by the Department pursuant to N.J.A.C. 7:27-22.12, after receipt and consideration of public comments on the draft operating permit. The Department forwards the proposed operating permit to EPA for review, pursuant to the procedures at N.J.A.C. 7:27-22.12 prior to the issuance by the Department of the final operating permit.

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"Quantifiable" means measurable with an acceptable degree of accuracy and reliability.

"Rate of production" means the quantity per unit of time of any process intermediate, product, by-product, or waste generated through the use of any equipment, source operation, or a process.

"Reconstruction of a major HAP facility" means, when used at N.J.A.C. 7:27-22.26, the replacement of components at a facility to such an extent that the fixed capital cost of the new components exceeds 50 percent of the fixed capital cost that would be required to replace the facility at which the components are being replaced.

"Renewal" means the procedure set forth at N.J.A.C. 7:27-22.30 by which an applicant may seek reissuance of an operating permit prior to its expiration date.

"Replace" means, in respect to equipment or control apparatus, to remove equipment or control apparatus and place or install a different piece of equipment or control apparatus at the same location and at the same point in the manufacturing process, provided that the newly placed equipment or control apparatus serves the same function, in the same manner.

"Replicable procedure" means a procedure, including any sampling, source emissions testing, or other monitoring procedure, which gives the same result when administered on a different occasion or by a different person.

"Responsible official" has the meaning defined for this term at N.J.A.C. 7:27-1.4.

"Research" means investigations directed toward the discovery of facts, scientific principles, reactions, or substances.

"Risk assessment" means a procedure for characterizing the probability that potential exposure to air contaminants will result in adverse effects on human health, or welfare or the environment.

"Seven-day-notice change" means, for the purpose of this subchapter, a change made at a facility covered by an operating permit in accordance with N.J.A.C. 7:27-22.22.

"Shutdown" means to discontinue use of a process, piece of equipment, control apparatus, or a source operation.

"SIC code" means the Standard Industrial Classification code, assigned by the United States Office of Management and Budget, which classifies establishments according to the type of economic activity in which they are engaged. An SIC manual is available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

"Significant modification" means a change made at a facility covered by an operating permit and incorporated into the operating permit in accordance with N.J.A.C. 7:27-22.24.

"Significant source operation" means any source operation which is not an exempt activity or an insignificant source operation.

"Source emission testing" means the testing of a discharge of any air contaminant from a source operation through any stack or chimney.

"Source operation" means any process, or any identifiable part thereof, that emits or can reasonably be anticipated to emit any air contaminant either directly or indirectly into the outdoor atmosphere. A source operation may include one or more pieces of equipment or control apparatus. This term includes the term "emissions unit" as defined at 40 CFR 70.2.

"Stack or chimney" means a flue, conduit or opening designed, constructed or used for emitting any air contaminant into the outdoor atmosphere.

"State Implementation Plan (SIP)" means a plan, or portion thereof, prepared by a State and approved by the EPA pursuant to 42 U.S.C. §7410, which includes enforceable emission limitations or other control measures, means or techniques, and provides for implementation, maintenance, and enforcement of one or more NAAQS.

"Substantial component" means, in respect to replacement, any equipment or control apparatus, or any component of equipment or control apparatus, if:

1. The total fixed capital cost exceeds:

i. For Category I sources, $20,000 as calculated in 1989 dollars; or

ii. For Category II sources, 50 percent of the total fixed capital cost of replacement or $20,000 as calculated 1989 dollars, whichever is greater;

2. The equipment or control apparatus, or the component, is designated in the conditions of approval of the permit in effect as a substantial component; or

3. The component is a burner having a rated heat input of 10 million BTU per hour or greater.

"Sulfur dioxide" or "SO_2" means a gas that has a molecular composition of one sulfur atom and two oxygen atoms.

"Temporary facility" means a facility which, by design, is intended to be operated at more than one location and which is relocated more than once in five years.

"Total suspended particulate matter" or "TSP" means any air contaminant dispersed in the outdoor atmosphere which exists as solid particles or liquid particles at standard conditions and is measured in accordance with N.J.A.C. 7:27B-1; 40 CFR 60, Appendix A, Methods 5 through 5H; or another method approved by the Department and EPA.

"TXS" means a substance regulated by N.J.A.C. 7:27-17.

"U.S.C." means the United States Code.

"Use" means, in respect to equipment, control apparatus, or a source operation, to engage in any form or manner of operation of equipment, control apparatus or the source operation subsequent to its installation. This term includes any trial operation.

"Volatile organic compound" or "VOC" means any compound of carbon (other than carbon monoxide, carbon dioxide, carbonic acid, metallic carbonates, metallic carbides and ammonium carbonate) which participates in atmospheric photochemical reactions. For the purpose of determining compliance with emissions limits or content standards, VOC shall be measured by test methods which have been approved in writing by the Department. This term does not include the compounds which EPA has excluded from its definition of VOC in the list set forth at 40 CFR 51.100(s)(1), which is incorporated by reference herein, together with all amendments and supplements. The list at 40 CFR 51.100(s)(1) currently includes the compounds and the classes of perfluorocarbons set forth below:

Compounds:
methane
ethane
methylene chloride (dichloromethane)
1,1,1-trichloroethane (methyl chloroform)
trichlorofluoromethane (CFC-11)
dichlorodifluoromethane (CFC-12)
trifluoromethane (FC-23)
1,1,1-trichloro-2,2,2-trifluoroethane (CFC-113)
1,2-dichloro-1,1,2,2-tetrafluoroethane (CFC-114)
chloropentafluoroethane (CFC-115)
chlorodifluoromethane (CFC-22)
2,2-dichloro-1,1,1-trifluoroethane (HCFC-123)
2-chloro-1,1,1,2-tetrafluoroethane (HCFC-124)
pentafluoroethane (HFC-125)
1,1,2,2-tetrafluoroethane (HFC-134)
1,1,1,2-tetrafluoroethane (HFC-134a)
1,1-dichloro-1-fluoroethane (HCFC-141b)
1-chloro-1,1-difluoroethane (HCFC-142b)
1,1,1-trifluoroethane (HFC-143a)
1,1-difluoroethane (HFC-152a)

Classes of perfluorocarbons:

Cyclic, branched, or linear, completely fluorinated alkanes

Cyclic, branched, or linear, completely fluorinated ethers with no unsaturations

Cyclic, branched, or linear, completely fluorinated tertiary amines with no unsaturations

Sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine

If there is any conflict between the list set forth at 40 CFR 51.100(s)(i) and the list set forth above, the list at 40 CFR 51.100(s)(l) shall control.

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7:27-22.2 Availability

(a) This subchapter applies to any facility which is one of the following:

1. A facility which emits or has the potential to emit (any determination of a facility's potential to emit shall include fugitive emissions), in the aggregate, any air contaminant in an amount which equals or exceeds the following applicability levels:

i. Twenty-five tons per year of VOC or NO_x;

ii. Ten tons per year of any HAP;

iii. Twenty-five tons per year of any combination of HAPs;

iv. Such lesser quantity of any HAP as the EPA may establish by rule, pursuant to 42 U.S.C. §7412(a)(1), as a major HAP facility; or

v. One hundred tons per year of any other air contaminant;

2. A facility subject to any standard or requirement for HAPs under 42 U.S.C. §7412, including any NESHAP; this does not include any facility for which 42 U.S.C. §7412(r), which pertains to prevention of accidental releases of HAPs, is the only applicable requirement;

3. An affected Title IV facility;

4. A facility with any source operation in a category designated by EPA pursuant to 40 CFR 70.3 as requiring an operating permit;

5. A facility with a solid waste incineration unit which combusts municipal waste and which has a combustion capacity greater than 250 tons of municipal waste per day; or

6. A facility for which an owner or operator elects to obtain an operating permit pursuant to (d) below.

(b) Notwithstanding (a) above, a facility is not subject to this subchapter if the only applicable requirement which applies to the facility is:

1. A requirement pursuant to 40 CFR 60, Subpart AAA, Standards of Performance for New Residential Wood Heaters; or

2. A requirement pursuant to 40 CFR 61, Subpart M—National Emission Standard for HAPs for Asbestos, Section 61.145, Standard for Demolition and Renovation.

(c) For the purposes of determining applicability pursuant to (a) above, an owner or operator may elect to treat any part(s) of a facility, which part(s) is used solely for research and development operations, as a separate facility. If any research and development operations of a facility are treated separately for the purposes of (a) above, The emissions or the potential to emit of those operations may be considered separately from the emissions or potential to emit of the remainder of the facility. However, research and development operations may not be treated separately for the purposes of any modeling or risk assessment required pursuant to N.J.A.C. 7:27-22.8.

(d) If a facility is not subject to this subchapter, but has equipment or control apparatus subject to the operating certificate requirements at N.J.A.C. 7:27-8, the owner or operator may voluntarily elect to obtain an operating permit for the facility in lieu of obtaining operating certificate(s) for the equipment or control apparatus.

7:27-22.3 General provisions

(a) The owner or operator of a facility subject to this subchapter shall obtain and maintain an operating permit for the facility pursuant to this subchapter.

(b) The owner or operator of a facility subject to this subchapter shall ensure that no person shall use or operate any equipment, control apparatus, or source operation at the facility without a valid operating permit for the facility, which covers the source operation.

(c) The owner or operator of a facility subject to this subchapter shall ensure that no air contaminant is emitted from any source operation, group of source operations, or any other portion of the facility at a rate that exceeds the applicable de minimis emission level set forth in Table A or B at N.J.A.C. 7:27-22.6, unless:

1. Emission of the air contaminant is authorized by the operating permit; and

2. The rate or concentration of the emissions does not exceed that authorized by the operating permit.

(d) A permittee shall ensure that any source operation, equipment or control apparatus covered by the operating permit, and all components connected to, attached to, or serving the source operation, equipment or control apparatus, are operated and maintained properly and according to the requirements of the operating permit.

(e) A permittee shall ensure that all requirements of the operating permit are met.

(f) Each owner and each operator of any facility, equipment, or source operation to which this subchapter applies is responsible for ensuring compliance with all requirements of this subchapter. If the owner and operator are separate persons, or if there is more than one owner or operator, each owner and each operator is jointly and severally liable for any fees due under this subchapter, and for any penalties for violation of this subchapter.

(g) Any provision of any other rule, statute or other source, incorporated into this subchapter, includes all future supplements and amendments to the incorporated source, unless the context of this subchapter clearly indicates otherwise.

(h) The provisions of (b), (c), (d), and (e) above shall not apply at a facility:

1. Prior to the earlier of the following two dates:

i. The date the operating permit is issued; or

ii. The date 18 months after the applicable deadline for applying for an initial operating permit, set forth at N.J.A.C. 7:27-22.5; or

2. If an application shield is in effect for the facility pursuant to N.J.A.C. 7:27-22.7.

(i) The term of an operating permit will be established in the operating permit. The Department will not issue an operating permit with a term of greater than five years.

(j) The expiration of an operating permit terminates the facility's right to operate unless an application shield is in effect pursuant to N.J.A.C. 7:27-22.7.

(k) The Department may, pursuant to N.J.A.C. 7:27-22.15, issue a single operating permit to an owner or operator of a temporary facility which will be operated in more than one location during the term of the operating permit. This single operating permit may authorize operation of the temporary facility at each of the locations approved by the Department in the operating permit.

(l) The Department may issue an operating permit which allows a facility to operate under one or more alternative operating scenarios, pursuant to N.J.A.C. 7:27-22.27, or which authorizes intra-facility emissions trading, pursuant to N.J.A.C. 7:27-22.28. Each alternative operating scenario or any intra-facility emissions trading for which an applicant seeks approval shall be proposed in the application for the initial operating permit, a minor modification, a significant modification, or a renewal, as appropriate. No change to an operating permit is required for any change in operation that is authorized by the operating permit pursuant to any approved alternative operating scenario or intra-facility emissions trading.

(m) The Department may issue an operating permit including an alternative emission limit, determined by the Department to be equivalent to, or more stringent than, that contained in an applicable requirement, provided that the alternative emissions limit has been demonstrated to be quantifiable, accountable, enforceable, and based on replicable procedures. An example of such an alternative emission limit would be use of a 0.5 percent sulfur limit on certain facility by-products to enforce the 310 part per million sulfur dioxide emissions limits in N.J.A.C. 7:27-9.2(e).

(n) An operating permit does not convey any property right, or any exclusive privilege.

(o) Any transfer of ownership or operational control of a facility covered by an operating permit, which would change the name or identity of the permittee for the facility, requires the transfer of the operating permit. An administrative amendment for such a transfer shall be submitted to the Department by the permittee prior to the transfer being made, in accordance with N.J.A.C. 7:27-22.20. No person to whom ownership or operational control is transferred shall commence operation at the facility until the application for the administrative amendment for the transfer has been received by the Department.

(p) Any change made at a facility subject to this subchapter, which constitutes a minor modification pursuant to N.J.A.C.

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7:27-22.23 or a significant modification pursuant to N.J.A.C. 7:27-22.24, shall also be subject to the requirement for a preconstruction permit for an alteration at N.J.A.C. 7:27-8. Any preconstruction permit issued for a facility subject to this subchapter shall be incorporated into the operating permit as a minor modification or a significant modification.

(q) Any person submitting an application, notice or report to the Department pursuant to this subchapter, or any permit, approval, authorization, order or other legal document issued pursuant thereto, shall include, as an integral part of the application or report, certification in accordance with N.J.A.C. 7:27-1.39.

(r) All information submitted to the Department pursuant to this subchapter shall be public information, unless the person submitting the information claims it as confidential in accordance with N.J.A.C. 7:27-1.8 through 1.30, and the Department determines that the information is entitled to confidential treatment in accordance with N.J.A.C. 7:27-1.8 through 1.30.

(s) The submittal of any information or application by a permittee including, but not limited to, an application for any change to the operating permit, any administrative amendment, any minor or significant modification, renewal, a notice of a seven-day-notice change, a notice of planned changes or notice of past or anticipated noncompliance, does not stay any operating permit condition, nor relieve a permittee from the obligation to comply with all applicable Federal, State, and local requirements.

(t) Application forms for operating permits and information pertaining to operating permits and the requirements of this subchapter are available at the following address:

Department of Environmental Protection and Energy
Air Quality Regulation Program
CN 027
Trenton, New Jersey 08625-0027
Attention: Operating permits
Telephone: (609) 633-8248

(u) If an additional applicable requirement becomes applicable to the facility, or an applicable requirement which was previously applicable to the facility changes, the permittee shall act to have the new applicable requirement or the change incorporated into the operating permit, in accordance with the procedures set forth in this subchapter.

(v) The Department may terminate an operating permit upon request of the permittee.

(w) Except as provided in the permit shield provisions at N.J.A.C. 7:27-22.17, an operating permit does not relieve any person from the obligation to comply with all applicable provisions of this chapter, including preconstruction requirements under N.J.A.C. 7:27-8, to obtain any other necessary authorizations from other governmental agencies, or to comply with all other applicable Federal, State, and local laws, rules or regulations.

(x) Notwithstanding the other provisions of this section, if any of the acid deposition control provisions of N.J.A.C. 7:27-22.29 conflicts with any other provision of the subchapter, the requirements of N.J.A.C. 7:27-22.29 shall prevail for an affected Title IV facility.

(y) If the facility is in operation, an applicant for an initial operating permit must obtain and, as applicable, renew all operating certificates required pursuant to N.J.A.C. 7:27-8 until the operating permit is issued by the Department.

(z) The provisions of this subchapter shall be operative on and after July 1, 1994.

7:27-22.4 General application procedures

(a) The procedures in this section apply to all applications submitted to the Department pursuant to this subchapter. Specific procedures for initial operating permits, administrative amendments, seven-day-notice changes, minor modifications, significant modifications, and renewals can be found at N.J.A.C. 7:27-22.5, 22.20, 22.22, 22.23, 22.24, and 22.30, respectively.

(b) Any application and any notice for a seven-day-notice change shall be submitted to the Department on forms obtained from the Department at the address at N.J.A.C. 7:27-22.3(t).

(c) If the applicant obtains prior written approval from the Department, an applicant may submit an application to the Department electronically, using predefined standards and information exchange protocols detailed in the Department's Technical Manual on Electronic Transfer of Information, available from the Department at the address listed at N.J.A.C. 7:27-22.3(t). This technical manual specifies a data dictionary and a file format, and any ANSI X12 compliant conventions required by the Department.

(d) Any application or notice shall be submitted to the Department at the address given in N.J.A.C. 7:27-22.3(t) and to EPA at the following address:

United States Environmental Protection Agency,
Region II
Air Compliance Branch
26 Federal Plaza, Room 500
New York, New York 10278

(e) An applicant for an initial operating permit, operating permit renewal or significant modification is advised to submit a complete application to the Department no less than 90 days prior to the applicable application deadline set forth in this subchapter. Within 30 days of receipt of such an application, the Department will issue a letter detailing any deficiencies in respect to administrative completeness in the application, thereby providing the applicant the opportunity to correct the deficiencies prior to the application deadline.

7:27-22.5 Application procedures for initial operating permits

(a)The application procedures in this section apply to all applications submitted to the Department for initial operating permits.

(b) The owner or operator of a facility subject to this subchapter shall submit a timely and administratively complete application for an initial operating permit. To be considered timely, an application for an initial operating permit shall be submitted to the Department no later than the applicable deadline established in this section.

(c) For any facility which commences operation prior to the applicable deadline below, the applicable deadline for submitting an administratively complete application for an initial operating permit is the earliest deadline below which applies to the facility:

1. For facilities with source operations subject to the acid deposition control program Phase II requirements for initial operating permits:

i. By January 1, 1996, for facilities with source operations subject to the requirements for SO_2 pursuant to 42 U.S.C. §7651d; and

ii. By January 1, 1998, for facilities with source operations subject to the requirements for NO_x pursuant to 42 U.S.C. §7651f;

2. Within 12 months after the effective date of EPA's designation, or by a later deadline specified by EPA in its designation, for facilities with any source operation designated by EPA pursuant to 40 CFR 70.3 as requiring an operating permit; and

3. For all other facilities, by the deadline in the table below:

SIC Code	Application deadline
2000 through 2199	11/15/94
4900 through 4910	11/15/94
4911(1)	11/15/94
4912 through 4939	11/15/94
6400 through 9999	11/15/94
4911(2)	5/15/95
4200 through 4399	5/15/95
5900 through 6399	5/15/95
7000 through 7199	5/15/95
7500 through 8299	5/15/95
0000 through 1299	11/15/95
1400 through 1999	11/15/95
3200 through 3599	11/15/95
4000 through 4199	11/15/95
4400 through 4499	11/15/95
4800 through 4899	11/15/95
5300 through 5499	11/15/95
1300 through 1399	5/15/96
2900 through 2999	5/15/96

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3600 through 3999	5/15/96
4500 through 4799	5/15/96
7300 through 7499	5/15/96
2200 through 2599	11/15/96
2700 through 2799	11/15/96
3000 through 3199	11/15/96
5000 through 5299	11/15/96
5500 through 5899	11/15/96
7200 through 7299	11/15/96
2600 through 2699	5/15/97
2835 through 2899	5/15/97
2800 through 2834	11/15/97
4940 through 4999	11/15/97

(1) If the facility is located in Atlantic, Burlington, Gloucester, Hudson, Hunterdon, Salem, Union, Camden, Monmouth, Sussex, or Warren County.

(2) If the facility is located in Bergen, Cape May, Cumberland, Essex, Mercer, Middlesex, Ocean, Morris, Passaic or Somerset County.

(d) If a facility or portion thereof becomes subject to a MACT or GACT standard pursuant to N.J.A.C. 7:27-22.26, prior to the applicable application deadline for the facility set forth in this section, the owner or operator shall submit an application for an initial operating permit. The application shall include only the source operations subject to the MACT or GACT standard, and shall be submitted to the Department by the deadline set forth at N.J.A.C. 7:27-22.26(l) or (m). In such a case, the Department will issue an operating permit covering only the equipment subject to the MACT or GACT standard.

(e) If a facility is issued an operating permit pursuant to (d) above, and if the MACT or GACT standard which is the basis for the issuance of the operating permit is the sole reason that the facility is subject to the requirements of this subchapter, the operating permit issued pursuant to (d) above shall be the only operating permit required for the facility. If a facility is issued an operating permit pursuant to (d) above, and the MACT or GACT standard which is the basis for the issuance of the operating permit is not the sole reason that the facility is subject to the requirements of this subchapter, an application for an operating permit for the entire facility shall be submitted according to the schedule at (c) above.

(f) For a facility that has not commenced operation as of the applicable deadline set forth above, the applicable deadline for submitting the application for an initial operating permit is 12 months after the date that the Department issues a preconstruction permit for the facility pursuant to N.J.A.C. 7:27-8. However, the owner or operator of such a facility is advised to submit an application at least 18 months prior to the planned commencement of operation, as the owner or operator is required to obtain an operating permit for the facility in accordance with the procedures of this section prior to commencing operation.

(g) For an existing facility that becomes subject to this subchapter through a change to any source operation, or to the use thereof, at the facility, the applicable deadline for submitting the application for an initial operating permit is:

1. If the change is one that would be a minor modification if an operating permit had been issued for the facility, 12 months after the changed source operation commences operation; or

2. If the change is one that would be a significant modification if an operating permit had been issued for the facility, 12 months before the changed source operation commences operation. In such case the owner or operator shall obtain an operating permit for the facility in accordance with the procedures of this section before the change is made.

(h) For a facility that becomes subject to this subchapter through a change to any applicable requirement other than a MACT or GACT standard, the applicable deadline for submitting the application for an initial operating permit is 12 months after the effective date of the new applicable requirement, unless a different application deadline is specified in the text of the new requirement.

(i) If a facility has over 100 stacks or chimneys, the owner or operator may elect to divide the facility into two or more components, and submit a separate application for an initial operating permit for each component. Such applications shall be submitted on a schedule proposed by the owner or operator and approved by the Department, except that the application for the final component shall be submitted no later than the application deadline established for the facility pursuant to (c) above. Notwithstanding the provisions of this subsection, any modeling or risk assessment required for the facility pursuant to N.J.A.C. 7:27-22.8 shall be performed on a facility-wide basis.

(j) The owner or operator shall provide a copy of the administratively complete application for an initial operating permit to the EPA and any affected state within 30 days of the determination that the application is administratively complete.

7:27-22.6 Application contents

(a) To be administratively complete, an application for an initial operating permit shall include all information required by this section and all application fees required pursuant to N.J.A.C. 7:27-22.31. The required information shall be provided on and with forms obtained from the Department, which will direct the applicant to set the information forth in a format such that the Department can incorporate the information readily into the draft operating permit.

(b) The required contents of an application for authorization to operate under a general operating permit, an administrative amendment, a minor modification, a significant modification, or a renewal of an operating permit are not set forth in this section, but rather are set forth at N.J.A.C. 7:27-22.14, 22.20, 22.23, 22.24, and 22.30, respectively. Requirements for submitting a notice of a seven-day-notice change are set forth at N.J.A.C. 7:27-22.22.

(c) Any source operation at a facility subject to this subchapter shall be included in the facility's application for an operating permit, except for exempt activities. A source operation shall be an exempt activity only if it is:

1. Not subject to preconstruction permit requirements pursuant to N.J.A.C. 7:27-8;

2. Not subject to any applicable requirement; and

3. One of the following types of source operations:

i. Source operations which have no potential for emitting any air contaminant, including, but not limited to:

(1) Stationary storage tanks which are used for the storage of water or distillates of air; and

(2) Enclosed stationary material handling equipment using pneumatic, bucket or belt conveying systems from which no emissions of air contaminants occur;

ii. Any of the following activities, if the activity supports the one or more production processes of the facility, and does not itself constitute a facility production process or a part thereof:

(1) Office activities and the equipment and implements used therein, such as typewriters, printers, and pens;

(2) Interior maintenance activities and the equipment and supplies used therein, such as janitorial cleaning products and air fresheners; this does not include any cleaning of production equipment;

(3) Bathroom and locker room ventilation and maintenance;

(4) Copying and duplication activities for internal use and for support of office activities at the facility;

(5) The activities of maintenance shops, such as welding, gluing, soldering; this does not include any such activities which are subject to preconstruction permit requirements pursuant to N.J.A.C. 7:27-8;

(6) First aide or emergency medical care provided at the facility, including related activities such as sterilization and medicine preparation;

(7) Laundry operations that service uniforms or other clothing used at the facility;

(8) Architectural maintenance activities conducted to take care of the buildings and structures at the facility, including repainting, reroofing, and sandblasting;

(9) Exterior maintenance activities conducted to take care of the grounds of the facility, including lawn maintenance;

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(10) Food preparation to service facility cafeterias and dining rooms; and

(11) The use of portable space heaters which reasonably can be carried and relocated by an employee; or

iii. The engine of any vehicle, including, but not limited to, any marine vessel, any vehicle running upon rails or tracks, any motor vehicle, any forklift, any tractor, or any mobile construction equipment;

iv. Storage tanks, reservoirs, containers, or bins used on any farm for the storage of agricultural commodities produced by or consumed in the farm's own operations. This does not include storage tanks, reservoirs, containers or bins used by distributors of agricultural commodities or by research facilities which develop products for use in agricultural production; or

v. Potable water treatment equipment, not including air stripping equipment.

(d) All source operations included in a facility's application shall be considered significant source operations unless the source operation satisfies the criteria for an insignificant source operation set forth in (e) below.

(e) In an application, an owner or operator may claim a source operation to be an insignificant source operation if:

1. The source operation is not subject to an applicable requirement;

2. The potential to emit of the source operation is less than any applicable de minimis emissions level set forth in Table A or B below;

3. The source operation is not subject to preconstruction permit requirements pursuant to N.J.A.C. 7:27-8; and

4. The source operation is one of the following:

i. Equipment used in a manufacturing process involving a surface coating operation or graphic arts operation including, but not limited to, spray and dip painting, roller coating, electrostatic depositing, surface stripping or spray cleaning, from which direct or indirect emissions of air contaminants occur and in which the quantity of coating or cleaning material used in any source operation is less than both of the following:

(1) One half gallon in any one hour; and

(2) Two and one-half gallons in any one day;

ii. An unheated open top surface cleaner having a top opening equal to or less than six square feet (0.56 square meters);

iii. A tank or vessel used in a process involving surface cleaning or preparation, including but not limited to, degreasing, etching, pickling, or plating, which has a capacity equal to or less than 100 gallons. This shall not include any tank or vessel which is an unheated open top surface cleaner having a top opening equal to or less than six square feet (0.56 square meters), a heated oven top surface cleaner, or a component of a conveyorized surface cleaner;

iv. Equipment, used in a process, other than as set forth in i, ii, or iii above, from which the direct and indirect emissions of each air contaminant occurs in amount(s) which are less than the applicable de minimis emission level set forth in Table A or B, below, and in which the combined weight of all materials, excluding air and water, introduced into any one source operation is 50 pounds in any one hour or less;

v. A stationary storage tank which has a capacity equal to or less than 10,000 gallons which is used for the storage of liquids other than applicable VOC;

vi. A stationary storage tank which has a capacity less than 2,000 gallons and which is used for the storage of applicable VOC;

vii. A tank, reservoir, container or bin which has a capacity equal to or less than 2,000 cubic feet and which is used for the storage of solid particles;

viii. Commercial fuel burning equipment having a heat input rate less than 1,000,000 BTU per hour to the burning chamber; this shall not include any incinerator or any equipment used for the burning of noncommercial fuel, crude oil, or process by-products in any form;

ix. Water treatment equipment if the concentration in the water of each TXS is less than 100 parts per billion by weight and the total concentration in the water of VOC is less than 3,500 parts per billion by weight;

x. Air stripping equipment with a capacity equal to or less than 100,000 gallons per day which is used in potable water treatment;

xi. A storage tank maintained under a pressure greater than one atmosphere provided that any vent serving such storage tank has the sole function of relieving pressure under emergency conditions; or

xii. Equipment used for woodworking which is vented into a room, including equipment used for sanding, drilling, cutting or planing unpainted wood or wood products.

Table A
Thresholds for De Minimis Emissions
of Hazardous Air Pollutants

Air Contaminant	Annual emissions (pounds per year)
Total dioxins and furans	0.0001
Benzidine	0.06
Bis (chloromethyl) ether	0.06
n-Nitrosodimethylamine	0.2
Hexavalent chromium compounds	0.4
Hydrazine	0.8
Arsenic and arsenic compounds	1.0
2-Nitropropane	1.0
Any Table A HAP (1)	2.0
Any Table B HAP (2)	20.0
Any other HAP	400.0

(1) This air contaminant category shall apply to any HAP listed in Table A at N.J.A.C. 7:27-8, Appendix I.

(2) This air contaminant category shall apply to any HAP listed in Table B at N.J.A.C. 7:27-8, Appendix I.

Table B
Thresholds for De Minimis Emissions
of Other Air Contaminants

Air Contaminant	Hourly emissions (pounds per hour)
VOC	0.05
TSP	0.05
PM-10	0.05
NOx	0.05
CO	0.05
SO2	0.05
Any other air contaminant	0.05

(f) An application for an initial operating permit shall include all information required by the application form, the instructions accompanying the application form, and the applicable completeness checklist(s) for the application. This shall include the following:

1. Information pertaining to the identification of the applicant, including:

i. The company name and mailing address, division name and the plant name and address (if different);

ii. The name and address of each owner, each owner's agent (if any), and each operator of the facility;

iii. The name and telephone number of the on-site facility manager and of any additional on-site contact person; and

iv. The name and address of any responsible official, as defined at N.J.A.C. 7:27-1.4;

2. For the source operations proposed to be insignificant source operations pursuant to (d) or (e) above, the following information:

i. The types of insignificant source operations found at the facility and the total number of each type of insignificant source operation;

ii. For all insignificant source operations collectively, an estimate of their total potential to emit, in the aggregate, each air contaminant; and

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iii. If so requested on the application form, for any type or class of insignificant source operations, an estimate of the total potential to emit each air contaminant of that type or class or source operations;

3. For each source operation at the facility which will be subject to the operating permit, other than exempt activities or those listed in (e) above as proposed insignificant source operations, information including, but not limited to, the following:

i. A brief description of the source operation;

ii. The identification number of any preconstruction permit issued by the Department for the source operation;

iii. Identification of any stack or chimney which serves the source operation and specification of:

(1) Any stack designation assigned by the Department for the stack or chimney; and

(2) Any stack designation assigned at the facility for any stack or chimney; and

iv. Identification of the production process in which the source operation is used;

4. A description of each of the facility's production processes and products, identified by SIC Code, in sufficient detail to determine which applicable requirements apply to the facility. This description shall set forth for each production process:

i. The significant source operations associated with the production process pursuant to (f)3iv above;

ii. The product(s) or intermediate product(s), together with any associated co-products, produced by the production process; and

iii. A description of the operating scenario used to produce the product(s) or intermediate product(s), and a description of any alternative operating scenarios which may be used to produce the same product(s) or intermediate product(s). Such description of an alternate operating scenario shall be prepared pursuant to N.J.A.C. 7:27-22.27;

5. The following information pertaining to emissions at the facility:

i. For each significant source operation, each air contaminant that it may emit and its potential to emit that air contaminant, including any fugitive emissions, in tons per year, and any other units required to verify compliance with any applicable requirement. If the source operation's potential to emit a given air contaminant does not exceed the applicable de minimis emissions threshold set forth in Table A or B above, the application shall state that the source operation does not have the potential to emit any air contaminant in a quantity that exceeds the applicable de minimis emissions threshold;

ii. For the facility, each air contaminant, if any, emitted as fugitive emissions and not associated with any source operation; the cause of that air contaminant being emitted as fugitive emissions; and the facility's potential to emit that air contaminant as fugitive emissions, in tons per year, and any other units required to verify compliance with any applicable requirement. However, if the facility's potential to emit a given air contaminant as fugitive emissions does not exceed the maximum exempt emissions threshold set forth in Table A or B above, the information required by this paragraph need not be given in respect to that air contaminant;

iii. For the facility as a whole, the facility's aggregate potential to emit, in tons per year, each air contaminant that may be emitted within the facility, including the emissions determined pursuant to (a)5i and ii above and the emissions estimated for insignificant source operations, as specified pursuant to (e) above;

iv. Identification of each stack or chimney at the facility and, for each stack or chimney, designation of which significant source operations are vented through the stack and chimney;

v. For each source operation, a listing of any fuels used and the maximum quantity of each commercial fuel or non-commercial fuel to be used annually;

vi. For each production process, the raw materials to be used, and either the maximum rate of production and the maximum annual hours of operation, or the maximum batch size and the maximum number of batches per year;

vii. For each source operation, a description of the control apparatus, if any, serving the source operation; if the control apparatus is not used for all operating scenarios, a description of the circumstances under which it is not used;

viii. For the facility, identification and description of all monitoring devices or activities proposed to verify compliance with applicable requirements;

ix. Any additional emissions information or emissions-related information needed to verify whether any potentially applicable requirement applies to the facility or to any source operation at the facility;

x. Any other information required by an applicable requirement;

xi. Any calculations upon which information in (f)5i through x is based; and

xii. For each criteria pollutant, any emission reductions which have been banked, pursuant to N.J.A.C. 7:27-18.8, and which are held by the owner or operator of the facility;

6. For each significant source operation at the facility or, if applicable, for each group of source operations or for the facility as a whole, information pertaining to air pollution control requirements as follows:

i. Each applicable requirement;

ii. For each applicable requirement, each provision of the applicable requirement which sets forth a maximum allowable emissions limitation, a limitation on operation affecting emissions, or a work practice standards affecting emissions applicable to the facility;

iii. The proposed permit conditions which incorporate and reflect each provision provided pursuant to (f)6ii above;

iv. Citation to the State or Federal rule, regulation, permit or other authority, which establishes each applicable requirement upon which the proposed permit conditions are based;

v. Identification of any difference in form between a proposed permit condition and the applicable requirement upon which the proposed permit condition is based; and

vi. If the owner or operator seeks to have, pursuant to N.J.A.C. 7:27-22.3(m), the operating permit include an alternative emission limit for any significant source operation or any group of significant source operations, a demonstration that:

(1) The proposed alternative emissions limit is equivalent to, or more stringent than, that contained in an applicable requirement; and

(2) The alternative emissions limit is quantifiable, accountable, enforceable, and based on replicable procedures;

7. An explanation of any proposed exemption from an otherwise applicable provision of an applicable requirement, including a citation of the legal authority authorizing the exemption;

8. A proposed compliance plan meeting the requirements of N.J.A.C. 7:27-22.9;

9. Any preconstruction permits issued by the Department pursuant to N.J.A.C. 7:27-8 prior to the date of application and any applications for preconstruction permits not yet finally acted upon;

10. The following information pertaining to modeling or risk assessment:

i. The modeling and risk assessment information required at N.J.A.C. 7:27-22.8 for the facility; or

ii. A statement that modeling and risk assessment are not required pursuant to N.J.A.C. 7:27-22.8 for the facility;

11. A statement that a copy of the application has been sent to EPA, and to any affected states or, if so requested by the Department, summaries of the application have been so submitted, in order to provide notice to the EPA and the affected states;

12. Certification of the application pursuant to N.J.A.C. 7:27-1.39; and

13. Any other information that is reasonably necessary to enable the Department to determine whether the applicant has satisfied the requirements of this subchapter for the issuance of a permit.

(g) Any applicant who seeks an operating permit authorizing the operation of a production process in one or more alternative modes shall propose these modes as alternative operating scenarios, in the application for an operating permit or significant modification, pursuant to N.J.A.C. 7:27-22.27. If the Department approves one

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or more alternative operating scenarios as part of an operating permit, the permittee may operate the process in any of the approved modes, and may change between those modes, without modifying the operating permit or notifying the Department.

(h) Any applicant who seeks an operating permit authorizing intra-facility emissions trading pursuant to N.J.A.C. 7:27-22.28 shall propose the intra-facility emissions trading in an application for an initial operating permit. An applicant may propose emissions trading for more than one group of source operations at the facility.

(i) Any applicant who seeks an operating permit including different emissions limits that apply to a source operation during startup, shutdown, or necessary equipment maintenance, shall propose such emissions limits in the application for the operating permit or significant modification. An applicant may propose such startup, shutdown, or maintenance emissions limits for more than one source operation in the application provided that these limits do not conflict with any state or federal regulation.

(j) An applicant may elect to propose, in the application for an initial operating permit, the methods to be used to determine the actual emissions of each significant source operation at the facility, for the purpose of preparing emission statements required for the facility pursuant to N.J.A.C. 7:27-21.

(k) Any applicant who seeks to include, as a component of the operating permit for the facility, authorization for the replacement of equipment during the term of the operating permit as a seven-day-notice change, pursuant to the provisions set forth at N.J.A.C. 7:27-22.22, shall request this in the permit application and include a schedule setting forth the expected dates of such replacement.

(l) Any applicant who, pursuant to N.J.A.C. 7:27-22.14, seeks to include as a component of the operating permit for the facility, one or more general operating permits shall specify the general operating permit(s) proposed to be included, identify each source operation to which the general operating permit would apply, and meet all other applicable application requirements set forth at N.J.A.C. 7:27-22.14. The conditions of such general operating permit, if applicable, will be incorporated into the operating permit for the facility.

(m) If an applicant seeks acknowledgement in the operating permit that any specific provision of a potentially applicable requirement does not in fact apply to the facility, the applicant may cite such a specific provision and request that the provision be specifically identified in the operating permit as being inapplicable to the facility.

(n) If an applicant for an initial operating permit seeks to have a compliance extension for a MACT or GACT standard incorporated into the operating permit, the applicant shall demonstrate in the application, pursuant to N.J.A.C. 7:27-22.26, that sufficient early reductions of HAP emissions have been achieved.

7:27-22.7 Application shield

(a) An application shield provides that the owner or operator of a facility subject to this subchapter will not be subject to penalties for operating the facility without an operating permit during the time the application shield is in effect.

(b) An application shield is in effect for a facility if:

1. The owner or operator of the facility has submitted to the Department an application for an initial operating permit or for a renewal, in accordance with N.J.A.C. 7:27-22.5 or 22.30, whichever applies; and

2. The application is administratively complete by the applicable deadline for submittal of the application, as set forth at N.J.A.C. 7:27-22.5 or 22.30, whichever applies.

(c) The protection afforded by the application shield begins the date the application is due to the Department.

(d) An application which is administratively incomplete at the time of the application deadline applicable to the facility, but which is later completed, is ineligible for coverage by an application shield. Similarly, an administratively complete application which is submitted after the applicable deadline for its submittal is ineligible for an application shield.

(e) An application shield does not relieve an applicant of the responsibility for compliance with all other requirements of this chapter, or any permit, order, or other legal document issued pursuant thereto.

(f) An application shield terminates automatically upon either of the following:

1. The Department's final action on the application for the initial operating permit or for the renewal; or

2. Failure of the applicant to submit additional information requested by the Department within the deadline established by the Department.

7:27-22.8 Air quality simulation modeling and risk assessment

(a) Except as provided at (b) and (c), below, an applicant for an initial operating permit shall perform air quality simulation modeling and risk assessment pursuant to this section and shall submit these to the Department with the application for the initial operating permit, if the facility's potential to emit exceeds any of the following thresholds:

1. For total dioxins and furans, 0.001 pounds per year;

2. For benzidine or bis (chloromethyl) ether, 0.6 pounds per year;

3. For n-nitrosodimethylamine, 2.0 pounds per year;

4. For hexavalent chromium compounds, 4.0 pounds per year;

5. For hydrazine, 8.0 pounds per year;

6. For arsenic and arsenic compounds, or for 2-nitropropane, 10.0 pounds per year;

7. For any HAP listed in Table A at N.J.A.C. 7:27-8, Appendix I, 20 pounds per year; or

8. For any HAP listed in Table B at N.J.A.C. 7:27-8, Appendix I, 200 pounds per year.

(b) Emissions from the combustion of natural gas or commercial fuel oil shall not be included in the determination of a facility's potential to emit for the purposes of this section.

(c) Notwithstanding (a) above, air quality simulation modeling and risk assessment are not required as part of an application for an initial operating permit which, pursuant to N.J.A.C. 7:27-22.5(d), covers only the equipment subject to a MACT or GACT standard if, pursuant to N.J.A.C. 7:27-22.5(e), the owner or operator will by a later deadline be submitting an application of an operating permit for the entire facility. In such a case, the requirement to perform air quality simulation modeling and risk assessment shall be postponed until the application for the operating permit covering the entire facility is submitted.

(d) An applicant for a renewal of an operating permit shall perform air quality simulation modeling and risk assessment pursuant to this section and shall submit these to the Department as part of the application for renewal if:

1. The applicant would be required to perform air quality simulation modeling and risk assessment pursuant to (a) above as part of an application for an initial operating permit;

2. The facility's potential to emit any HAP is more than 10 tons per year; or

3. The facility's potential to emit all HAPs collectively is more than 25 tons per year.

(e) An applicant for a significant modification shall perform air quality simulation modeling and risk assessment pursuant to this section and shall submit these to the Department as part of the application for a significant modification if the modification will result in an increase in the facility's potential to emit any air contaminant which exceeds any of the following thresholds:

1. For total dioxins and furans, 0.001 pounds per year;

2. For benzidine or bis (chloromethyl) ether, 0.6 pounds per year;

3. For n-nitrosodimethylamine, 2.0 pounds per year;

4. For hexavalent chromium compounds, 4.0 pounds per year;

5. For hydrazine, 8.0 pounds per year;

6. For arsenic and arsenic compounds, and for 2-nitropropane, 10.0 pounds per year;

7. For any HAP listed in Table A at N.J.A.C. 7:27-8, Appendix I, 20 pounds per year; or

8. For any HAP listed in Table B at N.J.A.C. 7:27-8, Appendix I, 200 pounds per year; or

9. For significant modifications which will not commence operation until after January 1, 2000:

i. Ten tons per year of any HAP; or

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ii. Twenty-five tons per year of any combination of HAPs.

(f) Any air quality simulation modeling and risk assessment submitted as part of an application for a significant modification pursuant to (e) above shall evaluate the effects of any increase in the potential to emit HAPs, due to the proposed construction or installation of new source operations or the proposed alteration of existing source operations.

(g) The air quality simulation modeling and risk assessment required pursuant to this section shall be performed in accordance with the Department's technical manual on Risk Assessment for Operating Permits. This technical manual provides for the following three levels of air quality simulation modeling and risk assessment:

1. Level-1 screening analysis, which entails a basic risk assessment screening using worksheets to determine if further analysis is necessary;

2. Level-2 routine analysis, which entails relatively simple computer modeling and risk assesment; and

3. Level-3 refined analysis, which entails detailed computer modeling and risk assessment.

(h) All applicants subject to (a), (d) or (e) above shall perform a Level-1 screening analysis, unless the applicant elects instead to perform a Level-2 routine analysis. In addition, if the risk levels determined through the Level-1 screening analysis:

1. Meet the health-based thresholds specified in the Department's Risk Assessment for Operating Permits technical manual, the applicant shall submit the Level-1 screening analysis as part of the application; or

2. Do not meet the health-based thresholds specified in the Department's Risk Assessment for Operating Permits technical manual, the applicant need not submit the Level-1 screening analysis as part of the application. Instead the applicant shall perform a Level-2 routine analysis.

(i) All applicants who perform a Level-2 routine analysis pursuant to (j) above shall submit the analysis as part of the application for an operating permit, renewal or significant modification. In addition, if the risk levels determined through the Level-2 analysis:

1. Meet the health-based thresholds specified in the Risk Assessment for Operating Permits technical manual, the applicant is not required to perform a Level-3 refined analysis; or

2. Do not meet the health-based thresholds specified in the Risk Assessment for Operating Permits technical manual, the applicant shall perform a Level-3 refined analysis pursuant to (j) and (k) below.

(j) A Level-3 refined analysis shall be performed in accordance with the protocol described in the Risk Assessment for Operating Permits technical manual, unless specific deviations from the protocol are approved in advance by the Department.

(k) An applicant who intends to perform a Level-3 refined analysis pursuant to (i) above shall submit as part of the application a proposed schedule for the completion of a Level-3 refined analysis, which will result in submittal of the Level-3 analysis to the Department within four months after the date the application is determined to be administratively complete pursuant to N.J.A.C. 7:27-22.10, Completeness review, or N.J.A.C. 7:27-22.30, Renewals, as applicable.

(l) In any risk assessment performed as part of a Level-3 refined analysis for an operating permit for a initial operating permit, an applicant need only consider the inhalation route of exposure. The Department may require consideration of other routes of exposure in a Level-3 refined analysis performed as part of an application for a renewal or a significant modification.

(m) An applicant shall base any air quality simulation modeling and risk assessment performed pursuant to this section on the entire facility's potential to emit. In addition, an applicant may also perform air quality simulation modeling and risk assessment based on the facility's actual emissions and submit this as supplemental information in the application.

(n) Air quality simulation modeling and risk assessment in addition to that required by this section may be required for a facility subject to the preconstruction permit requirements at N.J.A.C. 7:27-8 pursuant to that subchapter.

(o) If an applicant has performed air quality simulation modeling and risk assessment for the facility, pursuant to (a) above or to a State or Federal requirement, less than five years prior to the application for an operating permit, renewal or significant modification, the applicant may submit that analysis to satisfy the requirements of this section, provided that:

1. The previously performed air quality analysis provides information at a comparable level of accuracy and detail as is required by this section;

2. No change which could increase the level of HAP emissions has been made in the facility's operations or emissions since the modeling and risk assessment were performed; and

3. The applicant obtains the prior written approval of the Department for the substitution.

7:27-22.9 Compliance plans

(a) Pursuant to N.J.A.C. 7:27-22.6(f)8, an applicant for an initial operating permit shall submit a proposed compliance plan, drafted in accordance with this section, as part of an application for the initial operating permit.

(b) An applicant for a renewal, significant modification, or minor modification shall draft proposed revisions to any portion of the facility's compliance plan affected by any change to the facility made since the operating permit was issued. The proposed revisions shall be drafted in accordance with this section and submitted as part of the application for the renewal, significant modification, or minor modification.

(c) A proposed compliance plan shall include the following:

1. A decription of the current compliance status of the facility with respect to all applicable requirements;

2. For each applicable requirement, a statement setting forth the methods used to determine the facility's compliance status, including a description of any monitoring, recordkeeping, reporting or test methods, and any other information necessary to verify compliance with or enforce any proposed permit condition or any applicable requirement. This statement shall include, but is not limited to:

i. All monitoring, recordkeeping, reporting, or test methods required by any applicable requirement;

ii. Where the applicable requirement does not require monitoring, recordkeeping, reporting, or test methods sufficient to demonstrate the facility's compliance with the operating permit, proposed monitoring, recordkeeping, reporting, or test methods which:

(1) Are sufficient to demonstrate compliance; and

(2) Use terms, test methods, units, averaging periods, and other statistical conventions consistent with the applicable requirement; and

iii. Proposed requirements concerning the use, maintetnance, and installation of monitoring equipment and concerning monitoring, recordkeeping, reporting, or test methods. This shall include, but is not limited to, schedules for monitoring, recordkeeping, reporting, and source emissions testing; specification of parameters to be measured, recorded, and reported; and formats for recording and reporting;

3. A statement that source emissions testing and monitoring requirements will be carried out in accordance with N.J.A.C. 7:27-22.18, and that source emissions testing and monitoring will be conducted in accordance with a protocol approved by the Department;

4. A statement that recordkeeping and reporting requirements will be carried out in accordance with N.J.A.C. 7:27-22.19;

5. For each applicable requirement with which the facility is in compliance at the time the application for an operating permit is submitted to the Department, a statement that the facility will continue to comply with the applicable requirement;

6. For each promulgated applicable requirement which will become applicable to the facility after the application for an operating permit is submitted to the Department, but prior to the anticipated end of the term of the operating permit:

i. The date the provision will become applicable to the facility or to any part thereof;

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ii. A statement that the facility will comply with the applicable requirement on a timely basis; and

iii. A detailed compliance schedule, if such schedule is expressly required by the applicable requirement;

7. For each applicable requirement for which the facility is not in compliance at the time the application for an operating permit is submitted to the Department:

i. A narrative description of how the facility will achieve compliance with the applicable provision(s) of the applicable requirement;

ii. A proposed compliance schedule setting forth the remedial measures to be taken, including an enforceable sequence of actions with milestones leading to compliance. If the facility is subject to any order or consent decree, the proposed schedule of remedial measures shall incorporate the order or consent decree, and shall be at least as stringent as the order or consent decree;

iii. A schedule for submittal of progress reports every six months, or more frequently if specified by the underlying applicable requirement, order, consent decree; and

iv. A statement that the facility will comply with the compliance schedule on a timely basis and that the permittee will submit progress reports, certified in accordance with N.J.A.C. 7:27-1.39, in accordance with the schedule in (c)7iii above;

8. The following statements:

i. The permittee will ensure the compliance of the facility with the accidental release provisions at N.J.A.C. 7:31;

ii. The permittee will ensure the compliance of the facility with any employee trip reduction rules promulgated by DOT; and

iii. The permittee will ensure that any architectural coatings used at the facility conform with the standards set forth at N.J.A.C. 7:27-23; and

9. A schedule for the periodic submittal of compliance certifications, prepared in accordance with N.J.A.C. 7:27-22.19(f). Submittal shall be annual, or more frequent if so specified by the underlying applicable requirement or by the Department.

(d) If any source operation or any aspect of a facility's operation is in violation of any applicable requirement, and the facility is not subject to an order or consent decree for the violation, the owner or operator of the facility may request an administrative consent order from the Department to address the violation pursuant to N.J.A.C. 7:27A. A request to enter into an administrative consent order shall be submitted to:

Air Quality Enforcement
New Jersey Department of Environmental Protection and Energy
CN 422
Trenton, New Jersey 08625

(e) The Department's approval of a compliance plan or compliance schedule does not constitute any approval or sanction by the Department of any noncompliance with any applicable requirement, nor does it relieve any owner or operator from liability for penalties for any noncompliance.

7:27-22.10 Completeness review

(a) Within 30 days of receipt of an application for an initial operating permit, a renewal, a minor modification, or significant modification, the Department will:

1. Determine that the application is administratively complete, and so notify the applicant; or

2. Notify the applicant that the application is administratively incomplete, specify in writing the additional information required for the Department to commence review of the application, and provide a reasonable due date by which the applicant shall submit the information to the Department.

(b) An application shall be deemed administratively complete upon the earliest of the following dates that is applicable:

1. The date the application is submitted, if the Department does not notify the applicant, within 60 days of its receipt of the application, that additional information is required;

2. The date upon which any additional information requested in writing by the Department is submitted, if the Department does not notify the applicant, within 60 days of its receipt of the information, the further information is required; or

3. The date the applicant receives a notice of determination of administrative completeness from the Department pursuant to (a)1 above.

(c) The Department may request additional information from an applicant at any time after the submittal of an application, regardless of whether or not the application is administratively complete at the time of the Department's information request. A Department request for additional information in regard to an application which has been determined to be complete pursuant to (b) above shall not alter the administrative completeness status of the application.

(d) In a request for additional information, the Department shall establish a date by which the information is due to the Department. Upon receipt of a written request for additional time, the Department may extend the due date for the submittal of the additional information.

(e) If an applicant fails to submit the information requested by the Department by its due date, the Department shall deny the application. In addition, the Department shall void any application shield in effect pursuant to N.J.A.C. 7:27-22.7 as of the due date.

(f) If an application is denied, the applicant may reapply at any time. The new application shall meet all requirements for an operating permit application, including the requisite fee.

7:27-22.11 Public comment

(a) This section sets forth the procedures by which the Department will obtain comment from the public and affected states on each of the following:

1. A draft operating permit developed by the Department following the receipt of an administratively complete application for an initial operating permit;

2. A draft operating permit developed by the Department following the receipt of an administratively complete application for a significant modification of an operating permit;

3. A draft operating permit developed by the Department following the receipt of an administratively complete application for renewal of an operating permit; and

4. A draft general operating permit developed by the Department pursuant to N.J.A.C. 7:27-22.14(a).

(b) The Department will provide a public comment period on the draft operating permit, during which the Department will accept written comments on the draft operating permit. The public comment period will be specified in the notice published pursuant to (c) below, and shall be at least 30 days.

(c) The Department will provide public notice of the opportunity for public comment on each draft operating permit. The notice will:

1. Identify the facility that will be subject to the operating permit, and provide the name and address of the owner or operator;

2. Indicate whether the draft operating permit is an initial operating permit, a significant modification, a renewal or a general operating permit;

3. Indicate the type of production processes involved in the draft operating permit and, for a significant modification, the emissions change that will result from the modification;

4. Give the name and address of the Department, including the name and telephone number of a person at the Department from whom interested persons may obtain additional information;

5. Announce the opportunity for public comment, and provide a description of the public comment procedures set forth in this section;

6. Specify the length of the public comment period; and

7. Include the time and location of any public hearing to be held on the draft operating permit. If no public hearing is scheduled, the notice shall include procedures for requesting a public hearing.

(d) The Department will publish the notice for each draft operating permit in a newspaper of general circulation in the area where the facility which is the subject of the application is located and will mail the notice to persons on a mailing list developed by the Department, including to persons who request in writing to be on the mailing list. The Department may also provide additional notice

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by using any other means the Department finds appropriate for assuring adequate notice to the public of the opportunity for public comment.

(e) Whenever there is a significant degree of public interest, the Department will hold a public hearing on the draft operating permit. The Department may schedule a public hearing and include it in the notice of opportunity for public comment pursuant to (c) above or, if the Department does not schedule a hearing, any person may request that the Department hold a public hearing on a draft operating permit. A request for a public hearing shall be submitted in writing to the Department no later than the published date of the close of the comment period, and shall include a statement of issues to be raised at the public hearing.

(f) If a public hearing is held, the Department shall provide public notice of the public hearing at least 30 days in advance of the date the public hearing is scheduled.

(g) If in response to a request for a public hearing, the Department schedules a public hearing on a draft operating permit, the close of the public comment period shall be at 5:00 P.M. on the second State business day following the date of the public hearing. The Department may extend the comment period by announcing the extension and its duration at the public hearing.

(h) At any public hearing on a draft operating permit, the Department may, at its discretion:

1. Limit the time allowed for oral statements; and

2. Request a person offering oral testimony to submit the statement also in writing.

(i) The Department shall maintain for five years a record of all persons who provided oral or written comment during the public comment period for an operating permit and of the issues raised. Such records will be available to the public.

(j) The Department, on or before publishing notice of a draft operating permit pursuant to (b) above, shall also give notice to the head of the designated air pollution control agency of any affected state, and will accept and consider any comments which are received from the affected state prior to the close of the public comment period. If the Department does not accept any recommendation provided in writing by an affected state during the public comment period, the Department will so inform the affected state and EPA in writing, setting forth the Department's reasons for not accepting the recommendation.

7:27-22.12 EPA comment

(a) After the close of the public comment period and consideration of the comments on the draft operating permit, the Department will prepare a proposed operating permit for EPA review. The Department will provide a copy of the proposed operating permit to EPA, the applicant and, upon request, to any other interested person.

(b) The Department will transmit the proposed operating permit to EPA, together with a copy of the following:

1. Any information provided by applicant to the Department subsequent to the application being deemed administratively complete;

2. Any comments received from the public and from any affected state during the public comment period, and the Department's response to these comments; and

3. Any other supporting information necessary for EPA to review the application.

(c) If EPA objects to the proposed operating permit pursuant to the requirements of 40 CFR 70.8 during the 45 days following EPA's receipt of the proposed operating permit, the Department will revise the proposed operating permit to address EPA objection(s), and will submit the revised proposed operating permit to EPA, the applicant, and, upon request, to any other interested person.

(d) If the Department does not, within 90 days after its receipt of an objection from EPA, submit to EPA a proposed operating permit, revised to the satisfaction of EPA, the EPA may itself take final action on the application for an operating permit.

(e) If EPA does not object to the proposed operating permit within the 45 days following EPA's receipt of the proposed operating permit pursuant to (c) above or within 45 days following EPA's receipt of the revised proposed operating permit pursuant to (d) above, the Department will, after consideration of any comments submitted by EPA, the applicant, and other interested persons, take final action on the application pursuant to 7:27-22.13, except as provided in (g) below.

(f) If EPA does not object to the proposed operating permit within the 45 day period as set forth at (e) above, any person may petition the EPA during the 60 days after the expiration of EPA's 45-day comment period, and may request that EPA object to the proposed operating permit. Any petition to EPA shall be based only on an objection that was raised by the petitioner with reasonable specificity during the public comment period unless:

1. The petitioner demonstrates that it was impracticable for the petitioner to raise the objection during the public comment period; or

2. The grounds for the objection arose after the public comment period closed.

(g) If EPA, in response to a petition made pursuant to (f) above, objects to the proposed operating permit before the Department has issued the permit, the Department will not issue a final operating permit until the EPA's objection is addressed to EPA's satisfaction.

(h) If EPA, in response to a petition made pursuant to (f) above, objects to the proposed operating permit after the Department has issued a final operating permit, the EPA may itself modify, terminate, or revoke the operating permit.

7:27-22.13 Final action on an application

(a) The Department will take final action on an application:

1. For an initial operating permit, within 18 months after the Department's receipt of an administratively complete application for an initial operating permit, unless EPA objects to the proposed operating permit pursuant to 7:27-22.11;

2. For an application for an operating permit renewal, within 12 months after the Department's receipt of an administratively complete renewal application;

3. For an application for a minor modification, within 90 days after the Department's receipt of an administratively complete application;

4. For an application for group processing of minor modifications, within 180 days after the Department's receipt of an administratively complete application;

5. For an application for a significant modification, within 12 months after the Department's receipt of an administratively complete application; or

6. For an application for an administrative amendment, within 60 days after the Department's receipt of an administratively complete application.

(b) Except pursuant to (c) below, final action by the Department on an application for an initial operating permit, renewal, significant modification, or minor modification shall be:

1. Issuance of the final operating permit, modification, or amendment as proposed;

2. Determination that the improper procedure was followed for requesting a modification or Departmental action, and identification of the proper procedure for processing the modification or obtaining the Departmental action; or

3. Denial of the application.

(c) If the Department does not take final action on an application within the deadlines provided for each type of application, the applicant, and any person who commented on the draft operating permit during the public comment period, shall be entitled to bring an action, in accordance with N.J.A.C. 7:27-22.32, Hearings and appeals, to compel the Department to take final action on the application.

(d) After the Department has issued an initial operating permit, the Department will provide a copy of the initial operating permit, as issued, to EPA.

7:27-22.14 General operating permits

(a) The Department may issue one or more general operating permits, promulgated through rulemaking. Such rulemaking will be

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conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., except that such rulemaking procedures shall also incorporate the public comment procedures set forth at N.J.A.C. 7:27-22.11, EPA comment procedures set forth at N.J.A.C. 7:27-22.13, and any other procedural requirements related to the issuance of an operating permit.

(b) In accordance with the procedures set forth in this section, an owner or operator may apply to the Department for authorization under a general operating permit to operate any source operation, group of source operations, or facility which meets the applicability criteria set forth in a general operating permit issued by the Department. If the general operating permit applies to the entire facility, the general operating permit may serve as the operating permit for the facility. If the general operating permit applies to a part of the facility, the general operating permit may serve as a component of the operating permit for the facility.

(c) In an application for authorization to operate under a general operating permit, the owner or operator shall demonstrate how the facility or portion thereof:

1. Meets the applicability criteria set forth in the general operating permit; and

2. Will comply with all of the conditions of the general operating permit.

(d) A permittee shall operate a facility, or any portion thereof, for which authorization to operate under a general operating permit has been obtained from the Department, according to the terms and conditions of the general operating permit.

7:27-22.15 Temporary facility operating permits

(a) The Department may issue an operating permit to an owner or operator of a temporary facility which authorizes operation in more than one location during the term of the operating permit, provided that all locations at which the facility may be operated are listed in the application for the operating permit.

(b) An operating permit issued for a temporary facility shall require the permittee to:

1. Comply with all applicable requirements at all locations at which the temporary facility is operated;

2. Comply with all other applicable provisions of this chapter; and

3. Provide written notice, received at least 10 days in advance of each change in location, to:

i. The mayor of the municipality, or if there is no mayor, the governing body of the municipality to which the facility will be moved;

ii. The board of chosen freeholders or other governing body of the county to which the facility will be moved; and

iii. The Department at the address given at N.J.A.C. 7:27-22.3(t).

(c) The notice required pursuant to (b)3 above shall include:

1. The location being vacated;

2. The location to which the facility will be moved;

3. The name, address, and telephone number of the permittee;

4. The Department assigned permit number, which identifies the operating permit; and

5. As to the local officials identified in (b) above, a copy of the operating permit.

(d) An operating permit issued for a temporary facility shall not relieve any person from the obligation to comply with any provision of this chapter, to obtain any other necessary authorization from other governmental agencies, or to comply with all other applicable Federal, State, and local laws, rules or regulations.

7:27-22.16 Operating permit contents

(a) The Department will include in each operating permit, drafted for, or issued to, a facility, emission limitations and standards, including any operational requirement necessary to assure compliance with all applicable requirements which apply to a source operation or a group of source operations or to the facility as a whole at the time of permit issuance.

(b) For each significant source operation at the facility, or, if applicable, for each group of source operations or for the facility as a whole, the operating permit shall:

1. Specify each applicable requirement and each associated permit condition, including any emission limitations and standards and any operational requirements;

2. Cite to the specific legal authority, including any State or Federal rule or regulation or any permit, which establishes the applicable requirement and any associated permit conditions;

3. Identify any difference in form between the permit condition and the applicable requirement upon which the permit condition is based; and

4. Specify the test method (including a reference, if applicable, to where the test method is published) required to be used to determine compliance with the permit condition.

(c) If any other applicable Federal requirement is more stringent than an applicable requirement of EPA's acid deposition control regulations, both requirements shall be set forth in the operating permit pursuant to (b) above and both shall be enforceable by the Department and EPA.

(d) An operating permit may contain an alternative emission limit pursuant to N.J.A.C. 7:27-22.3(m), if:

1. The applicant has proposed the alternative emission limit in the application for the operating permit;

2. The applicant has proposed procedures that ensure that the alternative emissions limit is quantifiable, accountable, enforceable, and based on replicable procedures; and

3. The Department has determined, based on an equivalency demonstration provided by the applicant, that the alternative emissions limit proposed by the applicant is equivalent to, or more stringent than, that contained in an applicable requirement.

(e) The Department shall incorporate into each operating permit the provisions of any effective preconstruction permit and operating certificate issued for the facility, or any part thereof, if the preconstruction permit or operating certificate was:

1. Issued prior to the date the applicant submitted the application for the operating permit to the Department, and included by the applicant in the application; or

2. Issued subsequent to the date the application was submitted to the Department and prior to the date the Department issues the draft operating permit.

(f) Each operating permit shall contain a severability clause which ensures the continued validity of all other permit conditions in the event of a challenge to any part of the operating permit.

(g) Each operating permit shall include the following statements:

1. The permittee shall comply with all conditions of the operating permit. Any noncompliance with a permit condition constitutes a violation of the New Jersey Air Pollution Control Act N.J.S.A. 26:2C-1 et seq., and of the CAA, 42 U.S.C. §7401 et seq., and is grounds for enforcement action; for revocation or for reopening and modification of the operating permit; or for denial of an application for a renewal of the operating permit;

2. It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the conditions of this operating permit;

3. This operating permit may be modified, terminated, or revoked for cause by EPA pursuant to N.J.A.C. 7:27-22.12(h) and revoked or reopened and modified by the Department pursuant to N.J.A.C. 7:27-22.25;

4. The permittee shall furnish to the Department, within a reasonable time, any information that the Department may request in writing to determine whether cause exists for modifying, revoking and reissuing, or terminating this operating permit; or to determine compliance with the operating permit;

5. The filing of an application for a modification of an operating permit, or of a notice of planned changes or anticipated noncompliance, does not stay any operating permit conditon;

6. The operating permit does not convey any property rights of any sort, or any exclusive privilege;

7. Upon request, the permittee shall furnish to the Department copies of records required by the operating permit to be kept;

8. No permittee shall allow any air contaminant, including an air contaminant detectable by the sense of smell, to be present in the

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outdoor atmosphere in a quantity and duration which is, or tends to be, injurious to human health or welfare, animal or plant life or property, or which would unreasonably interfere with the enjoyment of life or property. This shall not include an air contaminant which occurs only in areas over which the permittee has exclusive use or occupancy;

9. The Department and its authorized representatives shall have the right to enter and inspect any facility subject to this subchapter, or portion thereof, pursuant to N.J.A.C. 7:27-1; and

10. The permittee shall pay fees to the Department pursuant to this chapter.

(h) An operating permit may contain alternative operating scenario(s) pursuant to N.J.A.C. 7:27-22.27, provided that:

1. The applicant has proposed the alternative operating scenarios in the application for the operating permit; and

2. The Department is satisfied, based on the information provided by the applicant, that the alternative operating scenario will not result in any exceedance of the emission limits established for the base operating scenario or in the emission of any new air contaminant at a rate that exceeds the applicable de minimis emission levels set forth in Tables A and B at N.J.A.C. 7:27-22.6 under the alternative operating scenario(s).

(i) For any alternative operating scenario included, the operating permit shall contain permit conditions, including, but not limited to, the following:

1. The permittee shall, contemporaneously with making a change from one operating scenario to another, record in a log maintained at the facility the changeover; and

2. The permittee shall ensure that operation under each such alternative operating scenario meets all permit conditions, applicable requirements, and the requirements of this chapter.

(j) An operating permit may contain provisions for intra-facility emissions trading within one or more groups of source operations, pursuant to N.J.A.C. 7:27-22.28.

(k) For any authorization of intra-facility emissions trading included, the operating permit shall contain permit conditions, including, but not limited to, the following:

1. The permittee shall maintain an emissions trading log at the facility in which the permittee shall record on a daily basis the emissions trading that has occurred; and

2. The permittee shall ensure that operation, notwithstanding the intra-facility emissions trading, meets all permit conditions, applicable requirements, and the requirements of this chapter.

(l) The operating permit shall contain provisions for the assertion of an affirmative defense to liability for penalties for any violation of the operating permit occurring as a result of an equipment malfunction, an equipment startup, an equipment shutdown, or during the performance of necessary equipment maintenance. The affirmative defense shall be asserted and established as required by P.L. 1993, c.89 (adding N.J.S.A. 26:2C-19.1 through 26:2C-19.5) and any rules and regulations that the Department promulgates thereunder, and shall meet all of the requirements thereof. The permit shall also contain a provision for the assertion of an affirmative defense of emergency to liability for penalties or other sanctions for noncompliance with any technology based emission limitation in the operating permit, provided that the affirmative defense is asserted and established in compliance with 40 CFR 70.6(g) and meets all the requirements thereof.

(m) If requested by the applicant and approved by the Department, an operating permit shall contain authorization for replacement of specific equipment during the term of the operating permit as a seven-day-notice change pursuant to N.J.A.C. 7:27-22.22(c)3 and a schedule when such replacement is allowed.

(n) Each operating permit shall include a compliance plan which includes all of the elements required for a proposed compliance plan pursuant to N.J.A.C. 7:27-22.9.

(o) Each operating permit shall include provisions to implement the testing and monitoring requirements of N.J.A.C. 7:27-22.18, and the recordkeeping and reporting requirements of N.J.A.C. 7:27-22.19.

(p) Each operating permit will include a permit shield pursuant to the provisions of N.J.A.C. 7:27-22.17. If requested by the applicant in the application and approved by the Department, an operating permit shield shall acknowledge that specific provision(s) of potentially applicable requirement(s) do not apply to the facility, cite any such specific provision(s), and state that compliance with the provision(s) is not required.

(q) Any other provision of this section notwithstanding, an operating permit issued pursuant to N.J.A.C. 7:27-22.26(g)1 may include only those source operations which are subject to the MACT or GACT standard which formed the basis for the issuance of the operating permit.

(r) If proposed by the applicant, pursuant to N.J.A.C. 7:27-22.6(j), and approved by the Department, the operating permit shall include the methods to be used to determine the actual emissions of each significant source operation at the facility.

(s) Each operating permit shall specify an expiration date which shall be no later than five years from the date of issue.

7:27-22.17 Permit shield

(a) The Department will include a permit shield in each operating permit. A permit shield provides that compliance with the conditions of the operating permit shall be deemed compliance with the specific applicable requirements which form the basis for these conditions, provided that the requirements of this section are met.

(b) A permit shield shall provided that:

1. For any applicable provision of an applicable requirement, if the provision is specifically included and identified in the operating permit, compliance with the provisions and conditions of the operating permit shall be deemed compliance with that provision of the applicable requirement; and

2. For any provision of a potentially applicable requirement, if the provision is specifically identified in the operating permit as not applicable to the facility, the permittee need not comply with the specifically identified provision.

(c) A permit shield shall cover the provisions of an initial operating permit, a renewal, and any change made pursuant to the procedures for significant modification at N.J.A.C. 7:27-22.24. Any change made pursuant to the procedures for administrative amendments, changes to insignificant source operations, seven-day-notice changes, or minor modifications, set forth at N.J.A.C. 7:27-22.20, 22.21, 22.22 or 22.23 respectively, shall not be covered by a permit shield.

(d) If an operating permit does not expressly include or exclude an applicable requirement, the applicable requirement is not covered by the permit shield and the permittee shall comply with its provisions to the extent they apply to the permittee.

(e) If it is determined that an operating permit was issued based on inaccurate or incomplete information provided by the permittee, any permit shield provision in that operating permit shall be void as to the portions of the permit which are affected, directly or indirectly, by the inaccurate or incomplete information.

(f) Neither a permit shield, nor any provision in an operating permit, shall alter or affect the following:

1. The emergency orders provisions of 42 U.S.C. §7603, including the authority of EPA under that section;

2. The liability of an owner or operator of a facility for any violation of any applicable requirement prior to or at the time of permit issuance;

3. The applicable requirements of the acid deposition control program, consistent with 42 U.S.C. §7651g(a);

4. The ability of EPA to obtain information from a facility pursuant to the requirements for recordkeeping, monitoring, inspections and entry at 42 U.S.C. §7414; or

5. The Department's authority to enter and inspect a facility subject to this subchapter, pursuant to N.J.A.C. 7:27-1.

(g) A permit shield does not alleviate any liability by the permittee for noncompliance with the operating permit.

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7:27-22.18 Source emissions testing and monitoring

(a) This section sets forth the procedures by which the Department will implement the source emissions testing and monitoring requirements contained in an approved operating permit.

(b) Within 90 days after approval of the operating permit, a permittee shall submit, pursuant to this section, a request for approval of a protocol prepared in accordance with requirements of the Department's technical manual on Air Contaminant Testing and Monitoring. The protocol shall describe how the permittee proposes to carry out any source emissions testing or monitoring required by the operating permit.

(c) The protocol shall, in accordance with the Department's technical manual on Air Contaminant Testing and Monitoring, include all details of the implementation of the source emissions testing and monitoring practices required by the operating permit and shall specify all sampling and analytical procedures, equipment specifications, example calculations, and the form in which data will be submitted.

(d) The Department will inform the permittee in writing of any deficiencies in the proposed protocol, and will provide a reasonable deadline for correction of the deficiencies. The permittee shall correct the deficiencies and resubmit the protocol to the Department within the deadline.

(e) If the operating permit requires source emissions testing, the permittee shall carry out the following initial source emissions testing procedures:

1. Contact the Department within 30 days after approval of the protocol and schedule a testing date;

2. Perform the source emissions testing within 180 days after the Department's approval of the operating permit, unless another time period is approved by the Department in writing; and

3. Submit the source emissions test report to the Department, within 30 days after completion of the source emissions testing, unless another time period is specified by the Department in writing. The test report shall include all raw field and laboratory data, as well as the operating and production parameters required by the approved protocol, so that the Department may reproduce the calculations and verify the findings of the test report and shall be reviewed and certified pursuant to (h) below before it is submitted to the Department.

(f) After completion of the initial source emissions testing required pursuant to (e) above, the permittee shall perform periodic source emissions testing in accordance with any applicable schedule in the operating permit, the approved protocol, and this section.

(g) If the operating permit requires monitoring using a CMS, the permittee shall perform the following initial procedures:

1. Install the CMS by the date specified in the operating permit;

2. Calibrate, operate and maintain all components of the CMS to measure continuously and record continuously the parameters specified in the operating permit in accordance with the approved monitoring protocol;

3. For facilities required to install CEMs, contact the Department within 30 days after approval of the monitoring protocol and schedule a date for a performance specification test conducted in accordance with the approved protocol, to verify that the CEM is operating according to the requirements of the operating permit;

4. Perform the performance specification test prior to any required source emissions testing and within 90 days after the latter of the following events:

i. Installation of the CMS; or

ii. The commencement of operation of the equipment being monitored; and

5. Submit to the Department the performance specification report within 30 days after the completion of the performance specification test. The performance specification report shall include all raw field and laboratory data necessary for the Department to reproduce the test results as specified by the approved protocol and shall be reviewed and certified pursuant to (h) before it is submitted to the Department.

(h) Each source emissions test report or performance specification test report shall be reviewed and certified, pursuant to N.J.A.C. 7:27-1.39, by a licensed professional engineer or by an industrial hygienist certified by the American Board of Industrial Hygiene.

(i) Each permittee shall meet all requirements of the approved protocol during the term of the operating permit.

7:27-2.19 Recordkeeping and reporting

(a) Each permittee shall maintain records of all source emissions testing or monitoring performed at the facility and required by the operating permit, for at least five years from the date of each sample, measurement, or report. Each permittee shall maintain all other records required by the operating permit for a period of five years from the date each record is made.

(b) Source emissions testing or monitoring records shall contain, at a minimum, the following information:

1. The date, source operation, and time of sampling or measurements;

2. The date(s) analyses were performed;

3. The company and the name of the person representing that company who was responsible for performing the sampling, measurements or analyses;

4. The analytical techniques or methods used;

5. The results of such analyses;

6. The operating conditions existing at the time of sampling or measurement;

7. All calibration and maintenance records, and all original strip-chart recordings, or the equivalent for continuous monitoring instrumentation;

8. Copies of all reports required by the operating permit; and

9. Any other information required by the Department to interpret the monitoring data.

(c) A permittee shall submit reports of all source emissions testing and monitoring required by the operating permit, and supporting information, to the Department every six months, beginning from the date of issuance of the operating permit, or more often if specified in the operating permit in accordance with (d) and (e) below. The reports shall conform to a format acceptable to the Department. The reports shall be certified pursuant to N.J.A.C. 7:27-1.39 by a responsible official.

(d) A report submitted pursuant to (c) above shall be submitted:

1. For a source emissions test report, within 30 days after the completion of the sampling, unless a longer period for submittal is approved in advance in writing by the Department; and

2. For a CMS report, within 30 days of completion of each calendar quarter for the calendar quarter.

(e) Any report submitted pursuant to (c) above shall clearly identify all deviations from operating permit requirements, including those attributable to emergencies, startup, shutdown and maintenance, the probable cause of such deviations, and any corrective actions or preventive measures taken.

(f) Each permittee shall submit a periodic compliance certification, in accordance with the schedule for compliance certifications set forth in the compliance plan in the operating permit. This periodic compliance certification shall include the following:

1. For each applicable requirement, a statement that the facility is:

i. In compliance with the applicable requirement;

ii. In compliance with a compliance schedule, included in the operating permit, which includes a sequence of actions with milestones leading to compliance with the applicable requirement;

iii. In compliance with an order or consent decree not incorporated into a compliance schedule; or

iv. Not in compliance;

2. For each applicable requirement, a statement of the methods used to determine the facility's compliance status, including a description of any monitoring, recordkeeping, and reporting requirements and test methods; and

3. Certification in accordance with the certification procedures at N.J.A.C. 7:27-1.39.

(g) Any deviation from operating permit requirements which results in a release of air contaminants in a quantity or concentration which poses a potential threat to public health, welfare or the environment or which might reasonably result in citizen complaints

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shall immediately be reported by the permittee to the Department on the Department hotline at (609) 292-7172, pursuant to N.J.S.A. 26:2C-19(e). Any deviation from operating permit requirements which results in a release of air contaminants in a quantity or concentration which poses no potential threat to public health, welfare or the environment and which will not likely result in citizen complaints shall be reported in writing by the permittee to the Department by 5:00 P.M. on the second business day after the deviation occurred, except for deviations identified by source emissions testing reports.

(h) A permittee shall, upon the Department's request, submit any record relevant to the operating permit or to the emission of any air contaminant from the facility. Such record shall be submitted to the Department within 30 days of the request by the Department, or within a longer time period if approved in writing by the Department, and shall be transmitted on paper, on computer disk, or electronically, at the discretion of the Department.

(i) A permittee shall make all information in (a) through (d) above, as well as following, readily available for inspection at the facility at all times, pursuant to the Department's right to inspect the facility set forth at N.J.A.C. 7:27-1:

1. The operating permit together with any revisions thereto, including any administrative amendments, changes to insignificant source operations, seven-day-notice changes, minor modifications, and significant modifications;

2. An up-to-date diagram of the facility indicating:

i. The location of all source operations, including all equipment and control apparatus; and

ii. All stacks or chimneys, together with any stack designation included in the operating permit;

3. Records required by this section, and records relevant to the use of any source operation including, but not limited to, manufacturer's instructions for operation and maintenance, the kind and amount of air contaminants emitted, rates of production, and hours of operation;

4. Records documenting any construction, installation, or alteration, including the dates thereof, of any equipment or control apparatus during the term of the operating permit;

5. The date of commencement of operation of any equipment or control apparatus; and

6. Any preconstruction permit issued for the equipment or control apparatus.

7:27-22.20 Administrative amendments

(a) A permittee may make any of the changes to an operating permit set forth at (b) below at a facility subject to an operating permit through the procedures for an administrative amendment set forth in this section. The Department shall incorporate the change into the operating permit. If the requirements of this section are met, the permittee may, at its own risk, make the change at the facility upon submittal of the amendment, but no sooner.

(b) A change may be made as an administrative amendment if the proposed change is:

1. A change in company name or mailing address; division name; plant name or address; name or address of each owner's agent; or name or telephone number of the on-site facility manager, any additional plant contact, or of any responsible official (as defined at N.J.A.C. 7:27-1.4);

2. Correction of any typographical error, including a mistake in the spelling, punctuation, or formatting of text, but excluding a change to any word, term, number or usage which would allow an emission increase or would constitute a seven-day-notice change, minor modification, or significant modification;

3. A transfer of ownership or operational control of the facility;

4. A change in any company stack designation;

5. A decrease, not required by an applicable requirement, in the maximum allowable rate of emission of any air contaminant or category of air contaminants, provided that the decrease does not entail either any physical change made to equipment or control apparatus or any operational change;

6. A decrease, not required by an applicable requirement, in maximum allowable hours of operation per time period;

7. A decrease, not required by an applicable requirement, in maximum allowable rate of production, provided that the decrease does not entail any physical change made to equipment or control apparatus or any operational change; or

8. An increase in the frequency of any monitoring, recordkeeping or reporting required by the operating permit.

(c) A permittee shall, pursuant to (d) and (e) below, submit a timely and administratively complete application for any change being made pursuant to this section as an administrative amendment.

(d) To be deemed timely, an application for an administrative amendment shall be submitted to the Department and EPA prior to the change being made.

(e) To be deemed administratively complete, an application for an administrative amendment shall include the Department assigned operating permit number, a copy of the portion of the operating permit which will be affected by the administrative amendment, a description of and reason for the amendment, and a copy of the revised portions of the operating permit reflecting the administrative amendment. For a transfer of ownership or operational control of the facility, the administrative amendment shall also include the information required in (f) below.

(f) To process a transfer in ownership or operational control pursuant to (b)2 above, a permittee shall attach to the application for an administrative amendment a written agreement between the current and new permittees, specifying the date for the transfer of ownership or operational control, permit responsibility, coverage and liability.

(g) Within 60 days of the Department's receipt of an application for an administrative amendment, the Department shall:

1. Notify the permittee that the change was not eligible for processing as an administrative amendment. In this event, a permittee may be subject to penalties for noncompliance with the operating permit during the time the change was in effect, pursuant to N.J.A.C. 7:27A; or

2. Incorporate the administrative amendment into the operating permit.

(h) A change made through an administrative amendment shall not be covered by any permit shield contained in the operating permit.

(i) A permittee may elect to make as a minor modification any change authorized to be made as an administrative amendment.

7:27-22.21 Changes to insignificant source operations

(a) A permittee may, pursuant to this section, make certain changes to equipment, control apparatus or a source operation, or to the use thereof, without notifying the Department or EPA until the renewal of the operating permit. In the application for the renewal of the operating permit, the permittee shall identify these changes.

(b) Any change made to an insignificant source operation during the term of an operating permit, including the construction or installation of a new insignificant source operation or the shutdown of an existing insignificant source operation, may be made pursuant to the procedures set forth in (a) above, provided that the change does not cause:

i. The source operation to become subject to an applicable requirement;

ii. The potential to emit of the source operation to exceed any applicable de minimis emissions level set forth in Table A or B at N.J.A.C. 7:27-22.6; and

iii. The source operation to become subject to preconstruction permit requirements pursuant to N.J.A.C. 7:27-8.

(c) A record of any change made to an insignificant source operation during the term of an operating permit, including the construction or installation of a new insignificant source operation or the shutdown of an existing insignificant source operation, shall be maintained in a log book at the facility, if such change would change the information provided in the application for the currently effective operating permit. Upon the request of any authorized representative of the Department or EPA, the permittee shall make this log book available for review.

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(d) The permittee shall include all changes recorded pursuant to (c) above in the application for renewal of the operating permit.

(e) A change which is made pursuant to this section shall not be covered by any permit shield contained in the operating permit.

7:27-22.22 Seven-day-notice changes

(a) A permittee may make any of the changes at (c) below through the procedures for a seven-day-notice change set forth in this section. The Department shall attach the notice of the seven-day-notice change to the operating permit, but shall not revise the operating permit until the next application for a renewal. If the requirements of this section are met, a permittee may make a seven-day-notice change seven days after the Department's receipt of the notice of the change.

(b) Any other provisions of this section notwithstanding, no change may be made pursuant to this section if the change would:

1. Require an increase in any emissions limit established in the operating permit, including any maximum allowable emissions rate or concentration or any emissions cap;

2. Include construction, installation, or alteration of equipment or control apparatus; or would include replacement of equipment or control apparatus, or of any substantial component thereof, except as provided at (c)2, 3 or 11 below;

3. Change a monitoring, recordkeeping, or reporting requirement set forth in the operating permit, if the changed requirement would be inconsistent with, or less stringent than, the existing requirement; or

4. Constitute a modification under any provision of Title I of the CAA.

(c) Except as provided at (b) above, any of the following changes may be made as seven-day notice changes, pursuant to the procedures of this section:

1. A change in the contents of a storage tank, bin, silo or other storage container, for which a preconstruction permit and certificate are in effect, provided such change does not:

i. Involve the use or storage of any HAP; or

ii. Cause the storage tank to become, pursuant to N.J.A.C. 7:27-16.2(b), subject to any control requirement to which the storage tank was not previously subject;

2. Replacement of any equipment or control apparatus which is not a substantial component as defined at N.J.A.C. 7:27-22.1, provided that:

i. The replacement equipment or control apparatus operates on the same physical or chemical principle as that which is being replaced;

ii. The replacement equipment or control apparatus is equivalent to, or better than, for the purpose of air pollution control, that which is being replaced;

iii. A preconstruction permit or operating permit is in effect for the equipment or control apparatus; and

iv. The date of approval of the preconstruction permit authorizing the installation of the equipment or control apparatus being replaced is less than five years prior to the date of installation of the replacement equipment or control apparatus;

3. Replacement of any equipment or control apparatus which is a substantial component as defined at N.J.A.C. 7:27-22.1, provided that:

i. The replacement is authorized in the operating permit;

ii. The replacement is made in accordance with a schedule included in the operating permit or is identified in the permit or certificate as a spare component kept on site for replacement purposes; and

iii. The component being replaced was installed less than five years previous to the replacement;

4. Any of the following changes to a stack or chimney or the use thereof, provided that the change is in compliance with EPA stack height regulations promulgated at 40 CFR 51:

i. A change in the number of stacks or chimneys serving the equipment or control apparatus, provided that the change does not result in any discharge height lower than that of the tallest stack or chimney existing prior to the change;

ii. A decrease in the diameter of a stack or chimney, provided that the exhaust is vented upward;

iii. The replacement of an existing stack or chimney with a taller stack or chimney, provided that this results in an effective stack height which is no less than that existing before the change; or

iv. An increase in the exit temperature or volume of gas emitted from a stack or chimney;

5. Any reconfiguration to an alternate operating scenario, including to an alternate configuration or a change in the production process, not authorized in the operating permit in effect, provided that the notice to the Department of the change contains the information required at 7:27-22.27 and that the alternate operating scenario conforms with the requirements of that section;

6. Addition, replacement, or removal of auxiliary devices or appurtenances serving an equipment or control apparatus;

7. A change in the relative use, expressed in percent by weight, of any raw material in the operation of equipment or control apparatus or in the process, including the introduction of a raw material not authorized in the permit or certificate or operating permit in effect;

8. A decrease in the maximum allowable rate of emission of an air contaminant or category of air contaminants based on operational change, provided that the decrease does not entail any physical change made to an equipment or control apparatus;

9. A modification of an authorization for intra-facility emissions trading included in an operating permit pursuant to N.J.A.C. 7:27-22.28;

10. A change in operation, as provided for by N.J.A.C. 7:27-22.28, which implements intra-facility emissions trading not expressly allowed by the operating permit, provided that:

i. The intra-facility emissions trading is conducted pursuant to the following provisions of this chapter allowing such emissions trading:

(1) The mathematical combination provisions of N.J.A.C. 7:27-9.2(d);

(2) The emissions averaging provisions of proposed N.J.A.C. 7:27-19.6; or

(3) Any emissions averaging provisions of this chapter that expressly allow the averaging to be incorporated into an operating permit pursuant to this section;

ii. The intra-facility emissions trading is approved through a preconstruction permit issued by the Department pursuant to N.J.A.C. 7:27-8; and

iii. The permittee conforms with the intra-facility emissions trading provisions set forth at N.J.A.C. 7:27-22.28;

11. Modification of equipment or control apparatus, or installation of new equipment or control apparatus, provided that:

i. The equipment or control apparatus is at a facility with an approved facility-wide permit, as defined at N.J.A.C. 7:27-22.1;

ii. The modification or installation meets the criteria for an exemption for facilities with a facility-wide permit, set forth at N.J.A.C. 7:27-8.17; and

iii. The modification or installation would not constitute a significant modification pursuant to N.J.A.C. 7:27-22.24;

12. Incorporation into the operating permit of an applicable requirement which was not previously applicable to the facility, provided that:

i. The facility is operating in compliance with the applicable requirement as of the date it becomes applicable to the facility; and

ii. No change to any source operation or to any production process is made at the facility as a result of the applicability of the applicable requirement; or

13. Relocation of a temporary facility to a site not specifically authorized in the operating permit, unless:

i. Air quality simulation or risk assessment is required pursuant to N.J.A.C. 7:27-22.8(d); and

ii. The operating permit specifies that a minor or significant modification is required for the relocation.

(d) A permittee shall, pursuant to (e) and (f) below, submit a timely and administratively complete notice for any change being made, pursuant to this section as a seven-day-notice change.

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(e) To be deemed timely, a notice shall be submitted to the Department and EPA at least seven days prior to the change being made at the facility.

(f) To be deemed administratively complete, the notice shall include all information required by the form of notice obtained from the Department, which form shall require the following information:

1. A description of the planned change, and a statement of the reason the change is being made;

2. The date(s) or schedule for when the change will be made, or a description of the types of circumstances under which the change would be made;

3. The specific source operations that will be changed or will be affected by the change;

4. For each source operation given in (f)3 above, each air contaminant for which the quantity or rate of actual emissions would be increased or decreased as a result of the change, and the quantity of that increase or decrease, including any new air contaminant which may be emitted as a result of the change;

5. Specification of any permit requirement or applicable requirement that will be:

i. Complied with through the change; or

ii. No longer applicable as a result of the change;

6. A statement affirming that the facility will comply with all applicable requirements;

7. Certification of the notice of the change in accordance with N.J.A.C. 7:27-1.39; and

8. Any other information that is reasonably necessary to enable the Department to determine whether the notice satisfies the requirements of this section.

(g) To be administratively complete, any notice submitted pursuant to (c)11 above for a modification of equipment or control apparatus, or installation of new equipment or control apparatus, at a facility with an approved facility-wide permit, shall include a Pollution Prevention Plan Modification or Pollution Prevention Assessment pursuant to N.J.A.C. 7:1K-3 and 4.

(h) No permittee may make a change at a facility pursuant to this section unless the written notice of the change is complete and is received by both the Department and EPA at least seven days before the change is made.

(i) If the notice is not received by the Department at least seven days prior to the change, the permittee shall be liable for penalties for each day between the day the change was made, and the seventh day after the Department's receipt of the notice.

(j) Upon receipt of a notice of a seven-day-notice change, the Department will issue an acknowledgment of receipt of the notice and file the notice as an attachment to the operating permit. Such acknowledgement does not constitute approval by the Department of the change as a seven-day-notice change. The permittee shall include all such changes in the application for the next renewal of the operating permit, in accordance with N.J.A.C. 7:27-22.30.

(k) If the Department subsequently determines that the change filed with an operating permit pursuant to (i) above is not eligible for processing through seven-day-notice change procedures, the permittee shall be subject to penalties for noncompliance with the permit, pursuant to N.J.A.C. 7:27A-3, for each day during which the change was in operation. The Department's failure to notify a permittee that a change is not eligible for processing as a seven-day-notice change shall not be a defense to liability for such penalties.

(l) The permittee shall attach a copy of each notice submitted pursuant to this section to the copy of the operating permit the permittee maintains at the facility.

(m) The permit shield described at N.J.A.C. 7:27-22.17 shall not apply to any change made pursuant to this section.

(n) A permittee may elect to make as a minor modification, or as part of a significant modification, any change authorized to be made as a seven-day-notice change.

7:27-22.23 Minor modifications

(a) A permittee may make any change given at (c) below through the procedures for minor modifications set forth in this section. The Department shall, upon approval of an application for a minor modificaton, incorporate the changes into the operating permit.

(b) The proposed change may, at the permittee's risk, be made at the facility as soon as the administratively complete application or the minor modification is received by the Department, but no sooner. An administratively complete application for a minor modification shall include all the information required by this secton, including an approved preconstruction permit for the corresponding alteration. Any permittee who elects to implement the change proposed in an application for a minor modification prior to the Department's final action on the application (that is, between the time of the Department's receipt of the administratively complete application for a minor modification and the Department's final action on the application) shall comply with both the applicable requirements governing the change and the proposed minor modification. During this time, the facility need not comply with the existing permit provisions it seeks to modify. However, if the permittee fails to comply with the proposed permit provisions during this time, the existing permit provisions it seeks to modify may be enforced against it.

(c) Any of the following changes may be made as a minor modification, unless the change constitutes a significant modification pursuant to N.J.A.C. 7:27-22.23.

1. A change in the location of the point of discharge of any air contaminant from equipment or contol apparatus into the outdoor atmosphere, unless the change is authorized in the preconstruction permit or certificate in effect;

2. Replacement of equipment or control apparatus or of any substantial component thereof if:

i. The replacement equipment or control apparatus does not operate on the same physical or chemical principle as that which is being replaced;

ii. The replacement equipment or control apparatus is not equivalent to, or better than, for the purpose of air pollution control, that which is being replaced;

iii. The equipment or control apparatus is a substantial component, as defined at N.J.A.C. 7:27-22.1;

iv. No preconstruction permit or operating permit is in effect for the equipment or control apparatus; or

v. The date of approval of the preconstruction permit authorizing the installation of the equipment or control apparatus being replaced is more than five years prior to the date of installation of the replacement equipment or control apparatus;

3. The introduction of any new raw material to equipment or control apparatus for which no certificate or operating permit is in effect, including the change of contents of a storage tank for which no certificate is in effect;

4. Any of the following changes to equipment or control apparatus, or the use thereof, if the change may increase the concentration or rate of any air contaminant emission:

i. Addition, replacement, or removal of auxiliary devices or appurtenances;

ii. Change in the relative use, expressed in percent by weight, of any raw material in the operation of equipment or control apparatus or in the process, including the introduction of a raw material not authorized in the preconstruction permit or certificate or operating permit in effect; or

iii. Change in the production process in which the equipment or control apparatus is used;

5. Increase in the concentration or rate of emission of any air contaminant above that authorized by the preconstruction permit or certificate, or operating permit, in effect, including an increase in any maximum allowable emission rate or concentration, or any emissions cap;

6. Emission of any air contaminant not authorized by the preconstruction permit or certificate, or operating permit, in effect;

7. Any change to a stack or chimney or the use thereof, including any change to a stack dispersion parameter including, but not limited to, temperature, velocity, direction, or volumetric flow rate, if:

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i. The change is not in compliance with EPA stack height regulations promulgated at 40 CFR 51; or

ii. The change may result in an increase in the ambient concentration of any air contaminant;

8. Any change in the concentration of any air contaminant in the influent to existing control apparatus above that authorized in the preconstruction permit or certificate, or operating permit, in effect;

9. Any increase in the total hours of operation per time period or the rate of production above that authorized in the preconstruction permit or certificate, or operating permit, in effect;

10. Any change to equipment or control apparatus, or to the use thereof, if the change will result in a contravention of any State or Federal ambient air quality standard, any provision of N.J.A.C. 7:27, or any condition or approval of any preconstruction permit or certificate in effect; and

11. Any change which is eligible to be processed as an administrative amendment, a change to an insignificant source operation or a seven-day-notice change pursuant to N.J.A.C. 7:27-20, 22.21 or 22.22, respectively;

(d) A permittee shall, pursuant to (e), (f), (g), (h) and (s) below, submit a timely and administratively complete application for any change being made pursuant to this section as a minor modification.

(e) To be deemed timely, an application for a minor modification shall be submitted to the Department and EPA prior to the change being made at the facility.

(f) In order to be considered administratively complete, an application for a minor modification shall meet all application contents requirements for an initial operating permit set forth at N.J.A.C. 7:27-22.6, except that an application for a minor modification shall include only such information as is relevant to the proposed modification. In addition, the application shall include, at a minimum:

1. A description of the proposed change, the emissions resulting from the change, and any new applicable requirement which will apply if the change occurs;

2. A proposed draft operating permit reflecting the proposed change;

3. Certification by a responsible official, consistent with N.J.A.C. 7:27-1.39, that the proposed change is eligible to be processed as a minor modification pursuant to (c) above; and

4. Completed forms, available at the address in N.J.A.C. 7:27-22.3(t), for the Department to use to notify EPA and affected states of the proposed change.

(g) (Reserved)

(h) To be deemed administratively complete, any application proposing the incorporation into the operating permit of a new alternative operating scenario or a new authorization for intra-facility emissions trading, not authorized by the existing operating permit, shall also meet the requirements set forth at N.J.A.C. 7:27-22.27 or 22.28, respectively.

(i) An application for a minor modification shall be submitted simultaneously with the application for a preconstruction permit for the proposed change, required pursuant to N.J.A.C. 7:27-8. The Department will initiate the review of both applications simultaneously. However, the application for a minor modification shall not be deemed administratively complete until the Department approves the application for the preconstruction permit; and the time periods set forth in this section for Department action on an administratively complete application for a minor modification shall not begin until the preconstruction permit is approved.

(j) If the application for a minor modification is administratively incomplete, the Department may deny the application, or request additional information.

(k) If the Department's issuance of a preconstruction permit renders an application for a minor modification administratively complete, the Department will, within five working days, notify the EPA and any affected state that the application is administratively complete. EPA and affected states will have 45 days from their receipt of such notice to notify the Department of any objection to, or comment on, the application. Such objection or comment shall be sent to the Department at the address set forth at N.J.A.C. 7:27-22.3(t). Unlike applications for initial operating permits, significant modifications, and renewals, applications for minor modification applications do not require public comment.

(l) Within 90 days after the application for a minor modification is administratively complete, or 15 days after the completion of EPA's 45-day review period, whichever is later, the Department will:

1. Approve the modification;

2. Deny the modification;

3. Determine that the modification requires processing as a significant modification. In such a case, the Department will terminate the application and so notify the applicant; or

4. Revise the applicant's proposed operating permit modifications, approve the modification as revised, and transmit it to the applicant.

(m) Once the Department approves a minor modification, the Department will submit a copy of the revised portions of the operating permit to EPA.

(n) The Department will not take final action on an application for a minor modification until EPA's 45-day review period has expired, or until EPA has notified the Department that it will not object to the approval of the modification, whichever comes first, or until any EPA objections have been resolved.

(o) If the Department does not, in its final action on the application, accept any recommendation on the proposed minor modification submitted by an affected state, the Department wil notify EPA and the affected state of its reasons for not accepting the recommendation.

(p) An applicant may request that the Department group-process two or more applications for minor permit modifications meeting the requirements of (r) below. Under group processing procedures, a permittee may request that all pending applications for minor modifications be group-processed. The Department will then process the applications together, using the procedures set forth in this section for minor modifications, including the provisions at (r), (s) and (t) below, which apply specifically to group processing of minor modifications.

(q) Minor modifications may be submitted for group processing only if:

1. Each proposed permit modification meets the criteria in this section for minor permit modifications; and

2. The emissions increases which would be caused by the modifications would, in the aggregate, be less than the least of the following:

i. Ten percent of the total emissions allowed by the operating permit for the source operations for which the changes are requested. If the source operation emits more than one containment, the increase of each contaminant shall be calculated separately. For example, if a unit is permitted to emit 10 tons per year of SO_2 and 10 tons per year of lead, minor modifications could not be group processed unless the aggregate increase in SO_2 emissions resulting from the modifications would be less than one ton per year, and the aggregate increase in lead emissions resulting from the modifications would be less than one ton per year;

ii. Twenty percent of the threshold amount of the contaminant listed at N.J.A.C. 7:27-22.2(a)1, Applicability. For example, for a facility which emits VOCs, modifications could not be group processed unless the total emission increases of VOCs resulting from the modifications would be less than five tons per year; or

iii. Five tons per year.

(r) To obtain approval for group processing, the permittee shall submit an application on forms obtained from the Department at the address in N.J.A.C. 7:27-22.3(t), and shall meet the requirements of (h) and (i) above. In addition, to be deemed administratively complete, the application shall include a list of all of the facility's pending applications for minor modification, and a determination of whether the requested modification, aggregated with these other applications, equals or exceeds the threshold set under (q)2 above.

(s) On a quarterly basis or within five business days of receipt of an application for group-processing, whichever is earlier, the Department will notify EPA and affected States of the requested minor modifications.

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(t) The Department shall act on an application for a minor modification submitted for group processing within 180 days of receipt of the request for group processing or within 15 days after the end of EPA's 45 day review period, whichever is later.

7:27-22.24 Significant modifications

(a) Notwithstanding any other provision of this subchapter, a permittee is required to make any of the changes listed at (b) below pursuant to the significant modification procedures section set forth in this section. The Department shall, upon its approval of an application for a significant modification, incorporate the change(s) into the operating permit. The permittee shall not make the change proposed in an application for a significant modification until the Department has approved the significant modification.

(b) Any of the following changes shall be made as a significant modification:

1. A change which causes the facility to be subject to, or which would constitute a modification pursuant to, any of the following:

i. Emission offset requirements pursuant to N.J.A.C. 7:27-18.2(a) and (b);

ii. NSPS regulations at 40 CFR 60;

iii. NESHAPS regulations at 40 CFR 63;

iv. PSD regulations at 40 CFR 52; or

v. Federal visibility regulations promulgated pursuant to 42 U.S.C. §7491 or 7492;

2. A change which relaxes:

i. Any monitoring, recordkeeping or reporting required by the operating permit; or

ii. Any provision of the compliance plan, including any lengthening of the time that a source operation is in noncompliance beyond the schedule contained in the compliance plan;

3. A change which requires a case-by-case determination of an emission limitation or other standard contained in a State or Federal rule. This includes, for example, an application for a variance from a specific emission limit. This shall not include emission limitations or standards established in a preconstruction permit to incorporate advances in the art of air pollution control, as required pursuant to N.J.A.C. 7:27-8;

4. A relocation of a temporary facility to a site, other than is authorized in the operating permit, if air quality simulation modeling or risk assessment is required for the application pursuant to N.J.A.C. 7:27-22.8;

5. A change which establishes or changes a permit condition for which there is no corresponding underlying applicable requirement, and which the facility has assumed to avoid an applicable requirement to which the facility would otherwise be subject. Such conditions include:

i. A Federally enforceable emissions cap assumed to avoid classification as a major facility or to avoid becoming subject to:

(1) Emission offset requirements pursuant to N.J.A.C. 7:27-18.2;

(2) NSPS regulations at 40 CFR 60;

(3) NESHAPS regulations at 40 CFR 63;

(4) PSD regulations at 40 CFR 52; or

(5) Federal visibility regulations promulgated pursuant to 42 U.S.C. §7491 or 7492;

ii. An alternative emissions limit for early reductions of HAPs approved pursuant to N.J.A.C. 7:27-22.26 or the regulations promulgated under 42 U.S.C. §7412(i)(5);

6. Any incorporation into the operating permit of a new alternative operating scenario or a new authorization for intra-facility emissions trading, if such an incorporation does not qualify as a seven-day-notice change pursuant to N.J.A.C. 7:27-22.22, or a minor modification pursuant to N.J.A.C. 7:27-22.23; or

7. Any other change that does not constitute an administrative amendment, seven-day-notice change, or minor modification.

(c) A permittee shall, pursuant to (d) and (e) below, submit a timely and administratively complete application for any change at a facility which, pursuant to (b) above, constitutes a significant modification.

(d) To be deemed timely, an application for a significant modification shall be submitted to the Department and EPA at least 12 months prior to the planned commencement of operation of any source operation proposed to be modified.

(e) An application for a significant modification may, at the applicant's discretion, be submitted simultaneously with the corresponding application for a preconstruction permit for the proposed change, required pursuant to N.J.A.C. 7:27-8. The Department will initiate the review of both applications simultaneously. However, the application for a significant modification shall not be deemed administratively complete until the Department approves the application for the preconstruction permit; and the time periods set forth in this section for Department action on an administratively complete application for a significant modification shall not begin until the application for the preconstruction permit is approved. If the Department denies the application for the preconstruction permit, the Department shall also deny the application for the corresponding significant modification.

(f) To be deemed administratively complete, an application for a significant modification shall meet all application contents requirements for an initial operating permit set forth at N.J.A.C. 7:27-22.6, except that an application for a significant modification shall include only such information as is relevant to the proposed modification.

7:27-22.25 Department initiated operating permit modifications

(a) An operating permit may be revoked or reopened and modified by the Department pursuant to this section. Any Department initiated permit revocation or modification shall be processed by the Department in accordance with the procedures for a significant modification.

(b) Upon a written request from the Department, a permittee shall furnish to the Department, within 30 days or within a longer time period established by the Department in the request, any information that the Department may request to determine whether cause exists for revoking, or reopening and modifying the permit.

(c) At least 30 days prior to reopening an operating permit, the Department will notify the permittee that action is necessary to modify the operating permit and that the Department will revoke, or reopen and modify, the operating permit unless the permittee acts to apply for or otherwise implement the necessary modification(s). A shorter time period may be provided if the Deparment determines that continued operation of the facility under its current operating permit may adversely affect human health or welfare, or the environment.

(d) The notice of a reopening made pursuant to (c) above will contain a reasonable deadline for action by the permittee.

(e) The Department shall reopen and modify an operating permit if any of the following occur:

1. The permittee fails to act within the time specified in the notice in (d) above to incorporate any of the following into the operating permit:

i. An additional applicable requirement which has become applicable to the facility; or

ii. A change to an applicable requirement which was previously applicable to the facility;

2. The Department or EPA determines that the permit contains a material mistake or that inaccurate statements were made in establishing the emissions standards, limitations or other provisions or conditions of the permit;

3. EPA requires the reopening of an operating permit pursuant to 40 CFR §70.7(g); or

4. The Department or EPA determine that the operating permit must be revised to assure compliance with applicable requirements.

(f) No reopening is required to incorporate a new applicable requirement pursuant to (e) above, if the date the requirement will become applicable to the facility is later than the date on which the operating permit is due to expire, unless the original permit or any of its provisions and conditions has been extended pursuant to an application shield in accordance with N.J.A.C. 7:27-22.7.

(g) Subject to (f) above but notwithstanding any other provision of this section, the Department shall ensure, by initiating a reopening or otherwise, that final action to incorporate additional appli-

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cable requirements into an operating permit is completed within 18 months of the promulgation of the additional requirement.

(h) During the period that the reopening is pending, the permittee shall comply with both the newly applicable requirements which apply to the facility and to the provisions of the current operating permit.

(i) The Department may revoke an operating permit if the Department determines that continued use of the facility pursuant to the current operating permit poses a potential threat to public health, welfare, or the environment, or that emissions from the facility would unreasonably interfere with the enjoyment of life or property. The procedures for revocation will be those for initial permit issuance.

(j) If EPA notifies the Department that cause exists to revoke or reopen and modify an operating permit, the Department shall, within 90 days of its receipt of the notice, forward to the permittee a notice of the Department's intent to modify or revoke the permit, as appropriate no later than 90 days after the notice from EPA pursuant to (d) above; and will provide to EPA and the permittee a proposed determination of revocation, or of reopening and modification, as appropriate. EPA may authorize the Department to extend the 90-day deadline for provision of a proposed determination an additional 90 days, if the Department determines that additional information from the permittee, or submission by the permittee of an application for a minor modification or a significant modification, is needed.

(k) If EPA approves the determination proposed by the Department pursuant to (j) above, or fails to act on it within 90 days of EPA's receipt of the proposed determination, the Department shall proceed to finalize the proposed determination in accordance with the procedures for finalizing a significant modification.

(l) If EPA objects to the Department's proposed determination within 90 days, the Department has 90 days from receipt of an EPA objection to resolve any objection that EPA makes and to reopen, modify, and reissue, or to revoke, the operating permit in accordance with the EPA's objection, pursuant to the procedures for a significant modification.

(m) The provisions of this section shall not be construed to allow the extension of the compliance deadline in any applicable requirement. Implementation of applicable requirements shall proceed in accordance with any deadlines established in the applicable requirement.

7:27-22.26 MACT and GACT standards

(a) MACT and GACT standards are applicable requirements which limit emissions of HAPs from stationary source operations or facilities. There are two types of MACT standards: those promulgated by EPA as described in (b) below; and those established on a case-by-case basis as described in (c) below. GACT standards are promulgated by EPA for a category of area sources. Notwithstanding N.J.A.C. 7:27-22.3, this section shall take effect upon EPA's approval of the Department's operating permit program.

(b) A MACT or GACT standard may be established through EPA promulgation. Such an EPA-promulgated standard may apply to any facility or source operation, or category of facilities or source operations, which is subject to 42 U.S.C. §7412. Pursuant to 42 U.S.C. §7412, EPA is required to promulgate MACT standards for certain categories of facilities in accordance with a schedule prepared by EPA and proposed in the Federal Register on September 24, 1992 at 57 FR 44147-44158. A facility or source operation shall be subject to a MACT or GACT standard promulgated by EPA if:

1. The facility or source operation is in operation at the time the MACT or GACT standard is promulgated, and the facility or source operation meets the applicability criteria set forth in the MACT or GACT standard; or

2. The facility or source operation is subsequently proposed to be modified such that the facility would meet the applicability criteria set forth in the MACT or GACT standard.

(c) A case-by-case MACT standard shall be established for a facility or any source operation(s) which constitutes a major HAP facility if any of the following occur:

1. The proposed construction of a major HAP facility in an application for a preconstruction permit submitted to the Department;

2. The proposed reconstruction of a major HAP facility in an application for a preconstruction permit submitted to the Department;

3. The proposed modification of a major HAP facility in an application for a preconstruction permit submitted to the Department. However, this paragraph shall take effect only upon EPA's establishment of de minimis HAP emission levels pursuant to 42 U.S.C. §7412(g); or

4. The failure of EPA to promulgate the specific MACT standard applicable to the source operation or facility by the deadline set by EPA for such promulgation pursuant to 42 U.S.C. §7412.

(d) MACT and GACT standards are applied to a facility or to source operation(s) through an operating permit. An owner or operator of a facility subject to an EPA-promulgated MACT or GACT standard shall submit an application to the Department to have the MACT or GACT standard incorporated into the facility's operating permit pursuant to (e) and (g) below. An owner or operator of a facility subject to a case-by-case MACT standard shall submit an application to the Department for the case-by-case MACT standard pursuant to (f) and (h) below. If an owner or operator of a facility subject to a MACT or GACT standard fails to act to incorporate the MACT or GACT standard into its operating permit pursuant to this section, the Department will proceed with a Department initiated operating permit modification pursuant to N.J.A.C. 7:27-22.25, commence an appropriate enforcement action, or both.

(e) For a facility or source operation(s) subject to a MACT or GACT standard promulgated by EPA, an application to incorporate the MACT or GACT standard shall be submitted no later than the date, if any, specified by EPA in the MACT or GACT standard promulgation. If no date is specified by EPA, the application shall be submitted by the later of the following dates:

1. Twelve months after EPA's promulgation of the applicable MACT or GACT standard; or

2. Twenty-four months before the date, set forth in the notice of promulgation, by which the facility must comply with the MACT or GACT standard.

(f) For a facility or source operation(s) subject to a case-by-case MACT standard because of EPA's failure to promulgate a MACT standard by the deadline set for such promulgation, an application to incorporate the case-by-case MACT standard shall be submitted no later than 18 months after the deadline set for EPA promulgation. For a facility or source operation(s) subject to a case-by-case MACT standard for any other reason, the Department recommends that an application to incorporate the case-by-case MACT standard be submitted no later than:

1. For construction or reconstruction, at least 18 months prior to the expected commencement of operation;

2. For modifications where the increase in HAP emissions due to the modification equals or exceeds 10 tons per year of any individual HAP or 25 tons per year of all HAP collectively, at least 18 months prior to the expected commencement of operation; and

3. For modifications where the increase in HAP emissions due to the modification is less than 10 tons per year of any individual HAP and 25 tons per year of all HAPs collectively, prior to the commencement of operation.

(g) An application to incorporate a MACT or GACT standard promulgated by EPA into an operating permit, as required pursuant to (d) above, shall be made through the following procedures:

1. If the facility does not have an operating permit at the time a MACT or GACT standard becomes applicable to the facility, the owner or operator shall apply for an initial operating permit covering only the equipment subject to the MACT or GACT standard, in accordance with the procedures for initial operating permits at N.J.A.C. 7:27-22.5, within the deadlines set forth at (e) above. If the facility is subject to any applicable requirement other than the MACT or GACT standard, the owner or operator of the facility shall apply for an operating permit for the entire facility according to the schedule set forth in the application procedures provisions at N.J.A.C. 7:27-22.5; or

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2. If a facility has an operating permit at the time a MACT or GACT standard becomes applicable to the facility, the permittee shall apply in accordance with the following to incorporate the MACT or GACT standard into the operating permit:

i. If the facility is already meeting all requirements of the MACT or GACT standard, in accordance with the seven-day-notice procedures set forth at N.J.A.C. 7:27-22.22; or

ii. If the facility is not already meeting all requirements of the MACT or GACT standard, in accordance with the procedures for a significant modification set forth at N.J.A.C. 7:27-22.24.

(h) An application to incorporate a case-by-case MACT standard into an operating permit, as required pursuant to (d) above, shall be made through the following procedures:

1. For construction or reconstruction pursuant to (c)1 or 2 above, the procedures for a significant modification set forth at N.J.A.C. 7:27-22.24;

2. For modification where the increase in HAP emissions due to the modification equals or exceeds 10 tons per year of any individual HAP or 25 tons per year of all HAP collectively, the procedures for a significant modification set forth at N.J.A.C. 7:27-22.24;

3. For modifications where the increase in HAP emissions due to the modification is less than 10 tons per year of any individual HAP and 25 tons per year of all HAP collectively, the procedures for a minor modification set forth at N.J.A.C. 7:27-22.23; or

4. For a facility or source operation(s) subject to a case-by-case MACT standard because of EPA's failure to promulgate a MACT standard by the deadline set for such promulgation, the procedures for a significant modification set forth at N.J.A.C. 7:27-22.24.

(i) In an application to incorporate a case-by-case MACT standard into an operating permit, the application shall propose a case-by-case MACT standard for the facility or source operations. The Department encourages applicants to propose, where feasible, emission limits which are based on pollution prevention techniques rather than emission limits which are based on the use of control apparatus.

(j) The Department shall approve a case-by-case MACT standard proposed by an applicant pursuant to (i) above only if the case-by-case MACT standard represents the maximum degree of emission reduction achievable by the facility, taking into consideration the cost of achieving such reductions and any non-air quality health and environmental impacts and energy requirements and:

1. For a facility which is being constructed or reconstructed, is at least as stringent as the lowest emission level achievable in practice by the best controlled similar source operation;

2. For a facility which is being modified pursuant to (c)3 above, is at least as stringent as the emission limitation which would be achieved by the incorporation into any modified source operation of advances in the art of air pollution control developed for the kind and amount of HAP emitted by the modified source operations at the facility; or

3. For any category of facilities for which EPA has not promulgated a MACT standard within 18 months after the deadline for promulgation, is no less stringent than the emission limitation which would be achieved by the incorporation of advances in the art of air pollution control developed for the kind and amount of HAP emitted by any source operation at the facility, which would have been affected by the EPA promulgation.

(k) For a facility subject to a MACT or GACT standard promulgated by EPA, compliance with a MACT or GACT standard shall be achieved no later than the compliance date required by EPA in the MACT or GACT standard promulgation. If no compliance date is specified by EPA, compliance shall be achieved:

1. For a facility which has not commenced operation by the date of EPA's promulgation of the applicable MACT or GACT standard, by the time the facility commences operation; or

2. For a facility which has commenced operation prior to EPA's promulgation of an applicable MACT or GACT standard, as soon as practicable, as specified in the operating permit for the facility, but no later than three years after promulgation of the MACT or GACT standard.

(l) Notwithstanding the provisions of (k) above, the Department may allow a six-year extension of time for complying with a MACT or GACT standard promulgated by EPA for one or more source operations at a facility, if the source operation achieves sufficient early reductions of HAP emissions. To be eligible for such a compliance extension, an applicant shall demonstrate that, prior to EPA's proposal of the MACT or GACT standard applicable to the facility, the relevant source operation(s) at the facility achieved at least the following emission reductions:

1. Ninety percent of all non-particulate HAP emissions; and

2. Ninety-five percent of all particulate HAP emissions.

(m) An applicant seeking an extension pursuant to (1) above shall, in accordance with the procedures at 40 CFR 63.70 et seq., demonstrate, to the satisfaction of the Department, in the application for an operating permit:

1. The quantity of verifiable actual emissions released from the facility during a representative year no earlier than 1987. No year may be used as the representative year for which there is any evidence that emissions during that year are artificially or substantially greater than emissions in other years prior to implementation of emissions reduction measures; and

2. The emissions demonstrated in (m)1 above were reduced by an amount which equals or exceeds the standards given in (l)1 and 2 above, subsequent to the representative year and prior to the date the MACT or GACT standard was proposed by EPA.

(n) If the Department approves the compliance extension, the Department will incorporate the compliance extension into the operating permit for the facility. A source operation for which a compliance extension is approved, and incorporated by the Department into the operating permit, may delay compliance with the otherwise applicable MACT or GACT standard for six years after the compliance date set forth at (k) above, provided that all conditions of the operating permit are met, and the emission reductions demonstrated to have been achieved pursuant to (m) above, are maintained throughout that time.

(o) A compliance extension pursuant to this section shall not be available with respect to any standard or requirement promulgated by EPA to protect health and the environment pursuant to 42 U.S.C. §7412(f). If EPA promulgates such a health-based standard, any facility affected by the health-based standard shall comply with such standard according to the schedule set by EPA.

(p) For a facility subject to a case-by-case MACT standard, compliance with the MACT standard shall be achieved:

1. For a modified, newly constructed or reconstructed facility, by the date of commencement of operation of the modified, new or reconstructed facility; or

2. For a facility subject to a case-by-case MACT standard because of EPA's failure to promulgate a MACT standard, as soon as practicable, but not later than three years after the date EPA's promulgation of the MACT standard was due, pursuant to 42 U.S.C. §7412. The Department shall specify this compliance deadline for the facility in the operating permit.

(q) Any other requirement of this section notwithstanding, a facility for which construction or reconstruction is commenced after EPA proposes an applicable MACT or GACT standard, but before the MACT or GACT standard is promulgated, shall not be required to comply with the standard as promulgated until three years after the date construction or reconstruction is commenced, provided that the facility, as authorized in the preconstruction permit, complies with the MACT or GACT standard as proposed.

(r) Any other requirement of this section notwithstanding, a facility which has installed BACT, pursuant to a permit required under 40 CFR 52, or LAER, pursuant to N.J.A.C. 7:27-18, for a source operation which emits a HAP, prior to EPA's promulgation of an applicable MACT or GACT standard for the same HAP, shall not be required to comply with the MACT or GACT standard until five years after the date of that installation of BACT or LAER.

7:27-22.27 Alternative operating scenarios

(a) The Department will include an alternative operating scenario in an operating permit, if the emission rates or concentrations for

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each source operation included in the alternative operating scenario meet all applicable requirements. An alternative operating scenario may, as appropriate, be incorporated into a permit through:

1. An application for an initial operating permit, a significant modification, or a minor modification pursuant to N.J.A.C. 7:27-22.5, 22.24 or 22.23, respectively; or

2. A notice of a seven-day notice change pursuant to N.J.A.C. 7:27-22.22.

(b) The emission limit for a source operation included in an alternative operating scenario which is being added by a seven-day notice to an existing operating permit shall not exceed the maximum allowable emission limits in the existing operating permit for the source operation.

(c) At a facility authorized to operate under one or more alternative operating scenarios, the permittee shall maintain a log at the facility and record in the log, contemporaneously with making a change from one operating scenario to another, each changeover.

(d) The permittee shall ensure that operation under an alternative operating scenario meets all permit conditions, applicable requirements, and the requirements of this chapter.

(e) An applicant or permittee seeking authorization for an alternative operating scenario shall provide to the Department, in the application for an initial operating permit, significant modification, or minor modification, or in a seven-day-notice, at least the following information:

1. A description of the proposed alternative operating scenarios;

2. The specific source operations that are to be included in the proposed alternative operating scenarios;

3. The fuels that will be used under the proposed alternative operating scenarios, and the maximum quantity of fuel proposed to be used annually;

4. The product(s) that will be produced under the proposed alternative operating scenarios; and

5. The proposed date(s) or schedule (if known) of when the operation will be changed over from one alternative operating scenario to the other, or a descripion of the circumstances under which the operation will be so changed over.

(f) In addition to the information required at (c) above, the following information shall be provided to the Department if the alternative operating scenario is proposed to be added to an existing operating permit:

1. For each source operation included in the alternative operating scenario:

i. The maximum allowable emissions limits established in the operating permit for each air contaminant, if that air contaminant may be emitted at a rate that exceeds the applicable de minimis emission level set forth in Tables A and B at N.J.A.C. 7:27-22.6;

ii. A demonstration that each of the emissions limits listed pursuant to (f)1i above will not be exceeded under the proposed alternative operating scenario; and

iii. A demonstration that, under the proposed alternative operating scenario, no air contaminant not authorized by the existing operating permit will be emitted at a rate that exceeds the applicable de minimis emission levels set forth in Tables A and B at N.J.A.C. 7:27-22.6; and

2. Any operating parameter relevant to air contaminant emissions, which parameter is addressed or limited in the existing operating permit, that may be changed under the proposed alternative operating scenario. This shall include, but not be limited to, parameters such as the quantity or type of raw material used.

7:27-22.28 Intra-facility emissions trading

(a) Intra-facility emissions trading within an emissions cap shall be allowed at a facility subject to this subchapter if:

1. Authorization for intra-facility emissions trading is included in the operating permit approved by the Department or is established through a notice of a seven-day-notice change pursuant to N.J.A.C. 7:27-22.22(c)10 and in accordance with (h) below; and

2. The emissions trading conforms with the Federal emissions trading policy published on December 4, 1986, in the Federal Register, Volume 51. No. 233, or with any economic incentive program guidance issued by EPA.

(b) Intra-facility emissions trading shall be limited to the group of source operations and to the air contaminants authorized for emissions trading by the operating permit. The source operations included shall be a group of source operations proposed by the applicant and approved by the Department.

(c) Any owner or operator may seek authorization for intra-facility emissions trading in an application for an initial operating permit, a significant modification, or a renewal, as appropriate. Additionally, authorization for emissions trading pursuant to the mathematical combination provisions of N.J.A.C. 7:27-9.2(d), the emissions averaging provisions of N.J.A.C. 7:27-19.6, or through any emissions averaging provisions of this Chapter that expressly allow the averaging to be incorporated into an operating permit pursuant to this section, may be established through a seven-day-notice change pursuant to N.J.A.C. 7:27-22.22(c)10 or a minor modification.

(d) An application seeking authorization for emissions trading shall provide information to the Department including, but not limited to, the following:

1. A description of the planned intra-facility emissions trading;

2. A statement of the purpose for seeking intra-facility emissions trading at the facility. Such a statement shall indicate, for example, if the purpose of the emissions cap is to avoid being classified as a major facility or avoid becoming subject to requirements, such as:

i. Emission offset requirements pursuant to N.J.A.C. 7:27-18.2; or

ii. PSD regulations at 40 CFR 52;

3. Specification of any permit condition or applicable requirement that would be:

i. Complied with through intra-facility emissions trading; or

ii. No longer applicable as a result of the emissions trading;

4. The specific source operations that would be included in the emissions trading program;

5. For each source operation subject to the emissions trading program, each air contaminant for which the quantity or rate of actual emissions may be increased or decreased as a result of intra-facility emissions trading;

6. For each air contaminant, the proposed federally enforceable emissions cap for the group of source operations that are to be included in the emissions trading program;

7. A description of the types of circumstances under which decreases in emissions from one or more source operations will be used to offset increases in emissions from one or more other source operations;

8. Proposed permit conditions which will enable the Department readily to verify whether emissions from the source operations have exceeded the emissions cap; such permit conditions shall set forth replicable procedures sufficient to ensure that emissions are quantified and recorded and that compliance with the emissions cap is enforceable. Such replicable procedures shall include monitoring or source emissions testing, or both, and recordkeeping and reporting procedures;

9. A statement affirming that each included source operation shall operate in compliance with the applicable provisions of this chapter and with all other applicable requirements; and

10. Certification in accordance with N.J.A.C. 7:27-1.39.

(e) A permittee may modify operating permit provisions regarding intra-facility emissions trading through the procedures for a seven-day-notice change if:

1. The proposed emissions trading program meets the requirements set forth at N.J.A.C. 7:27-22.22(c)9;

2. The modification is a change to a source operation which is subject to the emissions cap and that change to the source operation is also eligible to be made by seven-day-notice change pursuant to N.J.A.C. 7:27-22.22; and

3. The modification would not result in the need to increase the emissions cap.

(f) If the Department approves intra-facility emissions trading in the operating permit, the Department shall establish in the operating permit:

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1. A Federally enforcable cap on the aggregate emissions for the group of source operations included in the intra-facility emissions trading authorized by the operating permit; and

2. Permit conditions which will enable the Department readily to verify whether emissions from the source operations have exceeded the emissions cap. Such permit conditions shall set forth replicable procedures, including monitoring, source emissions testing, recordkeeping, and reporting procedures, sufficient to ensure that emissions are quantified and recorded and that compliance with the emissions cap is enforceable.

(g) The Department shall not approve any intra-facility emissions trading proposed for an operating permit, if any State rule or Federal regulation, which is an applicable requirement, requires case-by-case approval of any increase in emissions from any source operation included in the emissions trading, unless such case-by-case approval has already been issued by the Department and EPA pursuant to the procedures in the applicable requirement.

(h) A permittee may implement an intra-facility emissions trading program explicitly authorized in the rules which have been approved as part of the SIP, even if such a trading program is not expressly authorized in the operating permit, provided that:

1. The intra-facility emissions trading is conducted pursuant to the following provisions of this chapter allowing such emissions trading:

i. The mathematical combination provisions of N.J.A.C. 7:27-9.2(d); or

ii. The emissions averaging provisions of proposed N.J.A.C. 7:27-19.6; or

iii. Any emissions averaging provisions of this chapter that expressly allow the averaging to be incorporated into an operating permit pursuant to this section;

2. The Department and EPA are provided notice of the permittee's intent to implement the intra-facility emissions trading program through the seven-day-notice change procedures set forth in N.J.A.C. 7:27-22.22, or through a minor modification or significant modification, as appropriate; and

3. The new intra-facility emissions trading program will not result in any increase in the aggregate maximum allowable emissions from the source operations included in the program.

(i) A permittee authorized to implement intra-facility emissions trading shall maintain an emissions trading log at the facility. In this log the permittee shall record on a daily basis the emissions trading that has occurred. Specifically, the log shall reflect for each day:

1. Whether the facility complied with the operating permit by operating within one or more emissions caps established for one or more groups of source operations; and

2. If compliance is achieved through meeting the emissions cap for any group of source operations and for any air contaminant, for that group of source operations and for that air contaminant the following information:

i. The actual emissions of each source operation per unit of time. The unit of time used for this record shall be the same as that in which the emissions cap is given. For example, if the emissions cap is given in pounds per hour, the record shall contain for that day the pounds of actual emissions for each hour of the day for each source operation; and

ii. The total emissions from all source operations in the group subject to the emissions cap per same unit of time as is used for (i)2i. above.

(j) The permittee shall ensure that operation, including operation pursuant to authorized intra-facility emissions trading, meets all permit conditions and applicable requirements, including the requirements of this chapter.

7:27-22.29 Affected Title IV facilities

(a) Applications for operating permits for affected Title IV facilities shall be processed by the Department in accordance with acid deposition control provisions set forth at 42 U.S.C. §7651a through 7651o and with the applicable provisions of 40 CFR 72.

(b) For any application for an operating permit, or for any portion of an application for an operating permit, being submitted pursuant to the acid deposition control provisions of 40 CFR 72, including those portions of the compliance plan pertaining to acid deposition control requirements, an applicant shall use nationally standardized application forms, which the Department will make available upon EPA's finalization of the forms.

(c) An administratively complete application for an initial operating permit for a facility, or for any portion thereof, subject to the acid deposition control requirements of Title IV of the CAA shall include all information required by the application form, including the name and address of any designated Title IV representative, as defined at N.J.A.C. 7:27-22.1.

(d) The compliance plan for an affected Title IV facility shall meet the requirements of N.J.A.C. 7:27-22.9, except to the extent that these requirements are superseded by the acid deposition control requirements set forth at 42 U.S.C. §7651a through 7651o or by applicable provisions of 40 CFR 72.

(e) The Department will take final action on an application for an operating permit, operating permit renewal, significant modification or minor modification to implement Phase II Title IV requirements within the deadlines set forth in the acid deposition control requirements at 42 U.S.C. §7651a through 7651o.

(f) Affected Title IV units subject to the acid deposition control requirements of the CAA are not eligible for authorization to operate under a general operating permit.

(g) The Department is not authorized to issue an operating permit to an owner or operator of a temporary facility which authorizes operation in more than one location during the term of the operating permit, if that temporary facility is an affected Title IV facility, as defined at N.J.A.C. 7:27-22.1.

(h) An operating permit for an affected Title IV facility shall contain a condition prohibiting emissions exceeding the allowances that the facility lawfully holds under Title IV of the CAA or the regulations promulgated thereunder.

(i) Neither a permit shield nor any provision in an operating permit shall, consistent with 42 U.S.C. §7651g(a), alter or affect the applicable requirements of the acid deposition control program.

(j) The Department shall reopen and modify an operating permit for an affected Title IV facility pursuant to the procedures at N.J.A.C. 7:27-22.25, if additional requirements (including excess emissions requirements) become applicable to the facility under the acid deposition control program at Title IV of the CAA. However, the Department shall not reopen an operating permit for the following:

1. Excess emissions offset plans which shall be deemed to be incorporated into the operating permit upon approval by the EPA; and

2. Increases in emissions that are authorized by allowances acquired pursuant to the acid deposition control program, provided that such increases do not require an operating permit revision under any other applicable requirement.

7:27-22.30 Renewals

(a) A permittee is required to renew the operating permit through the procedures set forth in this section. If an application for a renewal also incorporates any proposed change(s) for the facility, the Department may, upon its renewal of the permit, incorporate the change(s) into the operating permit. The permittee shall not make any change proposed in the application for renewal until the Department approves the renewal.

(b) The permittee shall submit, pursuant to (c) and (d) below, a timely and administratively complete application for the renewal of the operating permit.

(c) To be considered timely, an application for renewal shall be received by the Department at least 12 months prior to expiration of the operating permit.

(d) To be deemed administratively complete, an application for renewal of an operating permit shall include all information required by the application form for the renewal, which form shall require the following:

1. A summary of all the changes that have been incorporated into the operating permit through administrative amendments, minor

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modifications, or significant modifications during the past five-year term of the initial operating permit or the most recent renewal thereof;

2. Any additional changes to the operating permit which the permittee seeks to have included in the operating permit; for these changes the permittee shall set forth all information required pursuant to the procedures for an initial operating permit pursuant to N.J.A.C. 7:27-22.5;

3. Any changes which the permittee has submitted as a seven-day-notice change during the past five-year term, and which the permittee seeks to have incorporated into the operating permit;

4. A summary of the results of any source emissions testing or monitoring that has been performed during the past five-year term pursuant to the requirements of the operating permit or of any preconstruction permit issued for the source operations included in the operating permit;

5. The proposed methods to be used to determine the actual emissions of each significant source operation, for the purpose of preparing emission statements required for the facility pursuant to N.J.A.C. 7:27-21. Methods shall be included for determining emissions of VOC, NO_x, CO, SO_2, TSP, PM-10, Pb, and any other air contaminant for which the facility has a potential to emit which equals or exceeds 100 tons per year; however, no method shall be proposed for any air contaminant, if the owner or operator is not required to report that air contaminant pursuant to N.J.A.C. 7:27-21.3(a);

6. Proposed draft operating permit provisions reflecting any change in the facility or its operations made through a seven-day-notice change since the last operating permit issuance, and any changes to the facility or its operations proposed for inclusion in the renewed operating permit; and

7. Any other information that is reasonably necessary to enable the Department to determine whether the application for renewal of the operating permit satisfies the requirements of this subchapter for the renewal of an operating permit.

(e) Notwithstanding (d)5 above, a permittee is not required to propose methods to be used to determine the actual emissions of each significant source operation in an application for a renewal, if such methods have been included in the initial operating permit pursuant to N.J.A.C. 7:27-22.16(r). A permittee may however propose revisions, in an application for a renewal, to any method for determining actual emissions previously included in the operating permit, if the revised method would be no less accurate and reliable than the method previously incorporated in the existing operating permit.

(f) An application for the renewal of an operating permit may be required to include air quality simulation modeling and risk assessment for the facility, pursuant to N.J.A.C. 7:27-22.8.

(g) If an administratively complete application for renewal is received by the Department at least 12 months prior to the date the operating permit expires, the facility will be covered by the application shield set forth at N.J.A.C. 7:27-22.7.

(h) An application for renewal of an operating permit is subject to the requirements for public comment and EPA comment set forth at N.J.A.C. 7:27-22.11 and 22.12.

(i) Unless a facility subject to this subchapter is covered by an application shield pursuant to N.J.A.C. 7:27-22.7, the right to operate the facility terminates upon the expiration of its operating permit.

(j) After an operating permit has expired, the conditions of the operating permit remain enforceable until the operating permit is reissued, except as provided in acid deposition control regulations promulgated by EPA under Title IV of the CAA.

7:27-22.31 Fees

(a) The owner or operator of a facility subject to this subchapter shall submit operating permit fees in accordance with this section. Operating permit fees shall be adjusted annually based upon the formulas set forth in this section. There are two types of operating permit fees:

1. Application fees, determined pursuant to (d) and (e) below; and

2. Annual supplemental fees, determined pursuant to (f) below.

(b) All applications and notices submitted pursuant to this subchapter shall be accompanied by the fee required by this section. If an application or notice is submitted without the required fee, the application or notice shall be deemed administratively incomplete. Further, the Department will not accept or process any application or notice, or request for Department action, from any applicant or permittee whose supplementary operating permit fees are past due.

(c) All supplemental fees required by this section shall be submitted annually, pursuant to (h) and (i) below.

(d) Application fees for initial operating permits and renewals shall be calculated in accordance with the following procedure:

1. List the total number of pieces of equipment at the facility which are significant source operations, or a part of a significant source operation, as reported to the Department pursuant to the emissions statement requirements at N.J.A.C. 7:27-21.5(b)11; and

2. Multiply this total number of pieces of equipment by the present value of the applicable fee, as set forth in Table 1 below. The present value of the fee shall be determined by multiplying the fee amount from Table 1 by the percentage difference between the current annual Consumer Price Index and the 1994 Consumer Price Index.

(e) The fee for each significant modification, minor modification, notice of a seven-day-notice change, and administrative amendment shall be the applicable fee set forth in Table 1.

Table I
Schedule for Application Fees

Type of application	Fee
Initial Application	$125.00 per piece of equipment
Renewal	$125.00 per piece of equipment
Significant Modification	$500.00 per application
Minor Modification	$250.00 per application
Seven-Day-Notice Change	$200.00 per notice
Administrative Amendment:	
a. A change in company name or mailing address; division name; plant name; or address; name or address of any owner's agent; name or telephone number of the on-site facility manager, any additional plant contact, or any responsible official	$ 00 per application
b. A change in any company stack designation	$ 00 per application
c. Any other administrative amendment	$ 50.00 per application

Agency note: The Department is proposing at subsection (f) two alternatives for the calculation of supplemental fees. These are referred to herein as ALTERNATIVE SUPPLEMENTAL FEE CALCULATION A and ALTERNATIVE SUPPLEMENTAL CALCULATION B.

ALTERNATIVE SUPPLEMENTAL FEE CALCULATION A

(f) The supplemental fee shall be based on the number of pieces of equipment subject to the operating permit. This fee shall be determined in accordance with the following procedure:

1. List the total number of pieces of equipment at the facility which are significant source operations or a part of a significant source operation, as reported to the Department pursuant to the emissions statement requirements at N.J.A.C. 7:27-21.5(b)11; and

2. Multiply this total number of pieces of equipment by the present value of $136.00 in 1994 dollars. The present value of $136.00 in 1994 dollars shall be determined by multiplying $136.00 by the percentage difference between the current Consumer Price Index and the 1994 Consumer Price Index.

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ALTERNATIVE SUPPLEMENTAL CALCULATION B

(f) The supplemental fee shall be based on the facility's actual emissions for the calendar year preceding the year in which the fee is due. This fee shall be determined in accordance with the following procedure:

1. Give the facility's total actual emissions, in tons per year, for the preceding calendar year for each air contaminant, as reported to the Department pursuant to the emission statement provisions at N.J.A.C. 7:27-21;

2. Determine the quantity of each air contaminant to be summed to calculate the facility's total emissions, in tons per year as follows:

i. For VOC and NO_x, the quantity to be summed shall be the quantity of the facility's total actual emissions, in tons per year, listed in (f)1 above; and

ii. For any other air contaminant, the quantity to be summed shall be the quantity of the facility's total actual emissions, in tons per year, listed in (f)1 above, except that if the quantity of emissions exceeds 4,000 tons per year, the quantity to be summed shall be 4,000 tons per year;

3. Sum the quantities of each air contaminant determined in (f)2 above; and

4. Multiply this sum by the present value of $25.00 in 1989 dollars. The present value of $25.00 in 1989 dollars shall be determined by multiplying $25.00 by the difference between the current Consumer Price Index and the 1989 Consumer Price Index.

(g) The owner or operator of a facility for which fees are paid in accordance with this section is not subject to any otherwise applicable operating certificate service fees required by N.J.A.C. 7:27-8, Table A, items 2 and 4, and Table B, item 7, except for fees relating to any source operation which is not subject to the operating permit.

(h) For a supplemental fee submission, an owner or operator shall submit both the fee and a corresponding supplemental fee form to the Department no later than September 30 each year. The supplemental fee form shall be submitted to the address given at N.J.A.C. 7:27-22.3(t) and the fee shall be submitted to:

Department of Environmental Protection and Energy
Bureau of Revenue
CN 417
Trenton, New Jersey 08625

(i) Any owner or operator submitting supplemental fees shall set forth, on the supplemental fee form, the determination carried out pursuant to (f) above to calculate the amount of the fee.

(j) All fee payments required by this section shall be submitted to the Department as a certified check or money order made payable to the Treasurer, State of New Jersey.

(k) The Department will deposit all fees required by this section in an Operating Permit Regulation Fund. The Fund shall be non-lapsing and shall be dedicated solely for use by the Department in administering the operating permit program required by this subchapter. Monies in the fund may be used to hire and fund positions and procure necessary equipment and services adequate to perform the functions of the Department in administering the provisions of the operating permit program.

(l) Within two years after the approval by EPA of a full operating permit program pursuant to 40 CFR 70, the Department will review the fee requirements of this section. The Department will examine whether the fees required by this section accurately reflect the actual costs of administering the operating permit program. If not, the Department will propose revisions to this section which would adjust the fee requirements accordingly.

(m) To assist applicants in making the fee calculations required pursuant to this section, the Department will annually publish in the New Jersey Register a notice of administrative change, pursuant to N.J.A.C. 1:30-2.7, setting forth the adjusted present value of dollar amounts set forth in this section, and the operative dates thereof.

7:27-2.22 Hearings and appeals

(a) An adjudicatory hearing regarding a determination made by the Department pursuant to this subchapter may be requested and granted in accordance with N.J.A.C. 7:27-8.12.

(b) If a person does not have a right to request an adjudicatory hearing pursuant to N.J.A.C. 7:27-8.12, there is final agency action as to that person when the Department takes final action on the application.

(c) If a person does have a right to request an adjudicatory hearing pursuant to N.J.A.C. 7:27-8.12, there is final agency action as to that person when the Department denies the request for an adjudicatory hearing, or when the Commissioner issues a final decision on the matter, whichever is later.

(d) A person who wishes to appeal a penalty assessed for a violation of this subchapter may request an adjudicatory hearing pursuant to the procedures at N.J.A.C. 7:27A.

(e) The Department's failure to take final action on an administratively complete application for an initial operating permit, renewal, minor modification or significant modification, within the deadlines provided by this subchapter, shall constitute grounds for the commencement of an action in lieu of the prerogative writ of mandamus, to compel Departmental action on the application.

(a)

POLICY AND PLANNING

Emission Statements

Proposed New Rules: N.J.A.C. 7:27-21.8 and 21.9
Proposed Amendments: N.J.A.C. 7:27-21.1 through 21.5, and 21.10; and 7:27A-3.10

Authorized By: Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1B-3, 13:1D-9, and 26:2C-1 et seq., in particular N.J.S.A. 26:2C-9(c) and 19.

DEPE Docket Number: 48-93-08/156.

Proposal Number: PRN 1993-503.

A **public hearing** concerning this proposal will be held on:

Tuesday, October 12, 1993, at 10:00 A.M., at:
New Jersey Department of Environmental Protection and Energy
Hearing Room, 1st floor
401 East State Street
Trenton, New Jersey 08625

Submit written comments, identified by the Docket Number given above, by October 27, 1993, to:

Janis E. Hoagland, Administrative Practice Officer
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

The new rule and amendments will become operative 60 days after adoption by the Commissioner (See N.J.S.A. 26:2C-8).

The agency proposal follows:

Summary

The Department of Environmental Protection and Energy is proposing to revise N.J.A.C. 7:27-21, Emission Statements, in order to add provisions so that all facilities subject to the operating permit program will be required to submit emission statements to the Department. The new operating permit rules (N.J.A.C. 7:27-22) are proposed elsewhere in this issue of the New Jersey Register. The Department is also proposing two new sections to the emission statement rules to allow facilities to apply for an extension and to require facilities that "drop-out" to notify the Department. Additionally, the Department is proposing to amend the administrative penalties at N.J.A.C. 7:27A-3.10(e)21 for failure to comply with subchapter 21.

Background on N.J.A.C. 7:27-21

On March 15, 1993, a notice of adoption appeared in the New Jersey Register at 25 N.J.R. 1254(a). The new emission statement rules adopted in this notice were designed to serve three air emission reporting needs: the emission statement program as required at Section 182(a)(3)(B) of the Clean Air Act Amendments of 1990 (CAAA), the emission inventory as required at Section 182(a)(3)(A) of the CAAA, and the annual point

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source requirements at 40 CFR 51.321-323. The adopted rules require that facilities submit a detailed report of emissions if, in 1992 or any year thereafter, they had the potential to emit 10 tons or more of volatile organic compounds (VOC), 25 tons or more of oxides of nitrogen (NO_x), or 100 tons or more of carbon monoxide (CO). The adopted rules also require facilities to submit an emission statement if, in 1993 or any year thereafter, they have the potential to emit 100 tons or more of sulfur dioxide (SO_2), total suspended particulates (TSP) or respirable particulate matter (PM_{10}), or five tons or more of lead (Pb). All of the compounds currently required to be reported are criteria pollutants which have National Ambient Air Quality Standards (NAAQS).

Relation to Operating Permits

One of the operating permit requirements, set forth at 40 CFR 70.9(a), requires that "the State program shall require that the owners or operators of part 70 sources pay annual fees, or the equivalent over some other period, that are sufficient to cover the permit program costs and shall ensure that any fee required by this section will be used solely for permit program costs." New Jersey intends to use emission statement data submitted by facilities required to obtain operating permits as the basis for operating permit fees. For additional information regarding the proposed operating permit program see the notice of proposed new rules, N.J.A.C. 7:27-22, published elsewhere in this issue of the New Jersey Register.

Comments Received Regarding Reporting Hazardous Air Pollutants

In the response to comment 140, at 25 N.J.R. 1271 of the notice of adoption, the Department committed to revise subchapter 21 in order to include the reporting of Hazardous Air Pollutants (HAPs). In Title III of the Clean Air Act amendments of 1990, 189 toxic compounds were listed as HAPs. The Department believes that an improved data base of actual emissions of HAPs would improve the Department's ability to track emissions trends and to develop better strategies to reduce risks associated with exposure to emissions of HAPs. One way to obtain such a data base would be to require major sources of HAPs to report actual emissions of HAPs in the emission statement rules. Upon considering to add HAPs to the emission statement rules, the Department realizes that doing so would drastically increase the complexity of submitting and processing emission statements. Therefore, the Department has decided not to propose the reporting of HAPs in the emission statement rules at this time. Instead, the Department seeks comments on how to effectively include such reporting, particularly with respect to issues such as double-counting air contaminants that are defined as a HAP and are also defined as a VOC or a particulate, alternate reporting mechanisms, and the availability of test procedures or emission factors needed to report actual emissions of HAPs with an adequate degree of accuracy.

Summary of Amendments

At N.J.A.C. 7:27-21.1, Definitions, the Department is proposing to add definitions for the following terms: "operating permit," "order," "preconstruction permit" and "USC". The Department is revising the definitions of the terms "Federally enforceable" and "potential to emit" in order to achieve consistency with the same terms proposing at N.J.A.C. 7:27-22.1.

The Department is proposing a third column at N.J.A.C. 7:27-21.2(a) Table 1. This column indicates the first year in which the potential to emit a particular air contaminant would require a facility to begin to submit an emission statement. A facility would be required to submit an emission statement if the facility has the potential to emit threshold quantities of VOC, NO_X, or CO during 1992 or any year thereafter. A facility would be required to submit an emission statement if the facility has the potential to emit threshold quantities of SO_2, TSP, PM_{10}, or Pb during 1993 or any year thereafter. The Department is proposing to delete N.J.A.C. 7:27-21.2(c). This provision is no longer necessary because the years for which emission statements must be submitted for particular air contaminants is now indicated in Table 1. Additionally, the Department is proposing the deletion of the first phrase at N.J.A.C. 7:27-21.3(a) which, as originally proposed, references the phrase mentioned above.

Since the proposed operating permit rules not only apply to facilities that have the potential to emit certain air contaminants at or above threshold quantities, but also apply to other facilities that fall into certain categories (see proposed N.J.A.C. 7:27-22.2(a)2 through 6 of the notice of proposal for the operating permit rules published elsewhere in this issue of the New Jersey Register), the Department is proposing to add a provision to the emission statement rules at N.J.A.C. 7:27-21.2(b) which states that a facility must annually submit emission statements for the emissions of 1993 and thereafter if the facility is required to obtain an operating permit or if the facility volunteers to obtain an operating permit.

The Department is proposing additional language at N.J.A.C. 7:27-21.3(a) that would require a facility which must obtain an operating permit or which volunteers to obtain an operating permit to report all information regarding all sources of air contaminants on Table 1 and actual emissions in the emission statement it submits to the Department. This additional language is necessary in order for the Department to determine emissions fees pursuant to the operating permit program. If a facility is not required to obtain an operating permit or does not volunteer to obtain an operating permit, then the facility need only report any air contaminants which the facility has the potential to meet or exceed the thresholds at Table 1, except if the facility exceeds the threshold for VOC, NO_X, or CO, the facility must report information on source operations which emit and actual emissions of all three in its emission statement submittal.

The Department is proposing amendment of the text at N.J.A.C. 7:27-21.4(d). In the notice of adoption of the new emission statement rules on March 15, 1993, the citation of the certification requirements changed from N.J.A.C. 7:27-8.24 to N.J.A.C. 7:27-21.7, and the Department had not changed the reference to the certification requirements at N.J.A.C. 7:27-21.4(d). The Department is now proposing to reference the correct citation of the certification requirements.

At N.J.A.C. 7:27-21.5(b)11, the Department is proposing that facilities which are required to obtain or volunteer to obtain an operating permit shall include the number of significant sources in the emission statement submission. This would be necessary in the event that the Department bases the operating permit emission fees on equipment rather than actual emissions. Significant sources are specified at proposed N.J.A.C. 7:27-22.6(c) through (e) which appears elsewhere in this issue of the New Jersey Register.

At N.J.A.C. 7:27-21.5 Table 2, the Department is correcting the notes at the bottom of the table. Upon adoption of the new emission statement rules as published in the New Jersey Register of March 15, 1993, the Department added an additional method and code in the table; this addition changed the codes for the other methods. Upon adoption, the notes at the bottom of the table were not changed to correspond with the intended methods. Therefore, the Department is proposing to correct the error. Similarly, at N.J.A.C. 7:27-21.5(i)1iii, the Department is proposing to correct the referenced code from Table 2.

The Department is proposing recodification of N.J.A.C. 7:27-21.8, Severability, to N.J.A.C. 7:27-21.10.

The Department is proposing new procedures for requests for extensions at N.J.A.C. 7:27-21.8. These new rules would allow facilities to request an extension to submit an emission statement after April 15. Facilities would be able to request an extension to submit the emission statement between April 16 and May 15 without penalty. Any request for extension would need to include the Air Pollution Control Plant Identification Number (if one exists) for proper identification, the plant contact and telephone number and the responsible official's telephone number to facilitate any additional communication, the reasons and justifications as to why the extension is requested, and the date which the facility is committing to submit the emission statement.

At N.J.A.C. 7:27-21.8(d), the Department is proposing that a request for extension will be considered if the Department receives it on or before April 15. However, the Department recommends that a request for extension should be submitted no later than April 1. It is in the interest of the facility to submit a request for extension as soon as possible.

At N.J.A.C. 7:27-21.8(e), the Department is proposing to allow one additional request for extension as long as it receives it before the expiration of the original extension.

At N.J.A.C. 7:27-21.8(f), the Department is proposing that the Department would have 10 working days after receipt to respond to an extension request. The Department will grant an extension if the extension is necessary to prevent extreme hardship. At N.J.A.C. 7:27-21.9(g), the Department is proposing that if the Department does not respond to a request for an extension (that was submitted in accordance with the requirements) within 10 working days, the request for extension is automatically granted.

At N.J.A.C. 7:27-21.9, the Department is proposing a new requirement which states that a facility that had submitted an emissions statement in the previous year and believes that an emission statement does not

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need to be submitted because the facility no longer meets the applicability requirements at N.J.A.C. 7:27-21.2, shall notify the Department. This year, some facilities have sent letters to the Department that state that the facilities are not required to submit emission statements in 1993 because the facilities do not meet the applicability requirements. In reviewing these letters, the Department has determined that many facilities misinterpreted the applicability requirements. Therefore, to prevent unnecessary enforcement actions, to avoid facilities misinterpreting the applicability requirements, and to improve the accuracy of information in the Department's databases, the Department is providing new procedures for facilities to notify the Department that the facility believes the emission statement requirements no longer apply. Notifications should be submitted by February 1 in order to give the Department adequate time to review the notification. The Department will respond as soon as possible to such notifications with its determination as to whether it concurs that the facility need not submit an emission statement. If a facility submits a notification of non-applicability after February 1, the Department is under no obligation to respond with its concurrence, but will make every attempt to respond if adequate time for review is available.

The Department is proposing revision to the penalty for failing to certify an emission statement as required at N.J.A.C. 7:27-21.5(a). This increase in the penalty is consistent with the penalty for a violation of omission which is not intentional, deliberate, purposeful, knowing or willful as indicated at N.J.A.C. 7:27A-3.6(c)2.

The Department is also proposing revision to the penalty for failing to keep records. This increase of penalty is consistent with the existing penalty at N.J.A.C. 7:27-16.9(a). The description for violating N.J.A.C. 7:27-21.6(b) currently reads "Readily Available" which applies to the availability of simple forms, for example, posting of operating certificate. The records required to be kept and made available are more voluminous than the posting of an operating certificate and are more like the records required to be kept and made available in subchapter 16.

The Department is proposing a new penalty for violations of the proposed new section regarding notifications of non-applicability. The penalty amounts are similar to other penalties for violations of other minor notifications.

Social Impact

The Department expects the proposed amendments to have a positive social impact by requiring additional facilities to submit emission statements. Subchapter 21 will enable the Department to obtain more complete and reliable information as to the quantity of volatile organic compounds (VOC), oxides of nitrogen (NO_X), carbon monoxide (CO), sulfur dioxide (SO_2), total suspended particulate matter (TSP), respirable particulate matter (PM_{10}), and lead (Pb) being emitted by facilities in New Jersey. This information is crucial to the effective regulation of these criteria pollutants to protect public health and the environment.

The emission statements required under subchapter 21 are an important resource for use in the development of the Department's strategy to prevent and control the emissions of VOC, NO_X, CO, SO_2, TSP, PM_{10}, and Pb. The Department expects that it will obtain data enabling it to design and develop more precisely targeted, and therefore more effective, control strategies to attain and maintain the NAAQS. This data will also help the Department develop better informed strategies for monitoring compliance with promulgated standards and permit requirements, and thereby help ensure that anticipated emission reductions are in fact realized. The reporting requirements may also make owners and operators of subject facilities more aware of the extent of the emissions being released from their facilities. Such awareness may encourage facilities to make voluntary reductions in their emissions.

For the reasons discussed below, the proposed new rules will have a long-term positive social impact, by contributing to the more effective control of emissions of VOC, NO_X, CO, SO_2, TSP, PM_{10}, and Pb.

VOC and NO_X are precursors to the formation of ground level ozone. As part of its program to attain the NAAQS for ozone, New Jersey is required by the CAA to demonstrate significant progress toward reducing emissions of these precursors.

Short-term effects of elevated ozone concentrations on healthy exercising adults and children include coughing, painful breathing and loss of certain lung functions. The connection between respiratory disease and high levels of ozone have been reported by the University of Medicine and Dentistry of New Jersey (UMDNJ). After studying data from nine central New Jersey hospitals, UMDNJ researchers found that the incidence of asthma attacks rose from seven to ten percent when elevated levels of ozone were reported by the Department[1]. These effects are exacerbated in sensitive populations, particularly the elderly, those with pre-existing respiratory diseases and children who play outdoors. Long-term effects are also of concern, because much of New Jersey's population has been exposed to unhealthful levels of ozone throughout their lifetime. Although chronic effects have not been conclusively demonstrated, repeated exposure to ozone over a lifetime causes biochemical and structural changes in the lung and may be a causal factor in the development of chronic respiratory diseases.

Increased ozone levels also cause damage to foliage. One of the earliest and most obvious manifestations of ozone's impact on the environment is its impact on sensitive plants. Subsequent effects include reduced plant growth and decreased crop yield. A reduction in ambient ozone concentrations would mitigate damage to foliage, fruits, vegetables, and grains.

The oxidizing properties of ozone lead to accelerated degradation of various human-made materials such as rubber, plastics, dyes and paints. Attainment of the NAAQS for ozone would reduce the rate of degradation of both natural and synthetic materials, thus preventing excess expenditure on maintenance and replacement of property.

Carbon monoxide may cause adverse health effects when local concentrations become elevated. CO interferes with the oxygen carrying capacity of the blood, causing reduced awareness, dizziness, headaches, fatigue, and loss of consciousness. Exposure to high levels of CO has also been linked to increased incidence of arteriosclerotic heart disease. The health threat from CO is most serious for those who suffer from cardiovascular disease, particularly those with angina or peripheral vascular disease. Healthy individuals also are affected but only at higher levels[2]. EPA has established a maximum eight-hour average of nine parts per million and a maximum one-hour average of 35 parts per million, not to be exceeded once per year, as the NAAQS for CO.

The major health effects associated with high exposures to sulfur dioxide include effects on breathing, respiratory illness and symptoms, alterations in the lung's defenses, and mortality. Persons most sensitive to sulfur dioxide include asthmatics and individuals with chronic lung disease (such as bronchitis or emphysema) or cardiovascular disease. Children and the elderly may also be sensitive. Sulfur dioxide produces foliar damage to trees and agricultural crops. It and nitrogen oxides are major precursors to acidic deposition (acid rain), which is associated with a number of effects including acidification of lakes and streams, accelerated corrosion of buildings and monuments and visibility impairment.[2]

Nitrogen dioxide can irritate the lungs and lower resistance to respiratory infection (such as influenza). The effects of short-term exposure are still unclear but continued or frequent exposure to concentration higher than those normally found in the ambient air may cause increased incidence of acute respiratory diseases in children. Nitrogen oxides are an important precursor both to ozone and acid deposition and may affect both terrestrial and aquatic ecosystems. Atmospheric deposition of NO_X is a potentially significant contributor to ecosystem effects including algal blooms in certain estuaries such as the Chesapeake Bay.[2]

Exposure to lead can occur through multiple pathways, including inhalation of air and ingestion of lead in food, water, soil, or dust. Lead accumulates in the body in blood, bone and soft tissue. Because it is not readily excreted, lead also affects the kidneys, liver, nervous system and blood-forming organs. Excessive exposure to lead may cause neurological impairments such as seizures, mental retardation and/or behavioral disorders. Even at low doses, lead exposure is associated with changes in fundamental enzymatic, energy transfer and homeostatic mechanisms in the body. Fetuses, infants and children are especially susceptible to low doses of lead, often suffering central nervous system damage. Recent studies have also shown that lead may be a factor in high blood pressure and subsequent heart disease in middle-aged white males.[2]

Based on studies of human populations exposed to high concentrations of suspended particulates (often in the presence of sulfur dioxide), and laboratory studies of animals and humans, the major effects of concern for human health include effects on breathing and respiratory symptoms, aggravation of existing respiratory and cardiovascular disease, alterations in the body's defense systems against foreign materials, damage to lung tissue, carcinogenesis and premature mortality. The major subgroups of the population that appear likely to be most sensitive to the effects of particulate matter include individuals with influenza, asthmatics, the

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elderly and children. Particulate matter soils and causes damage to materials, and is a major cause of substantial visibility impairment in many parts of the U.S.[2]

Economic Impact

The proposed amendments to subchapter 21 will require approximately 150 additional facilities in New Jersey to maintain records and submit annual emission statements to the Department. The proposed amendments would increase the economic burden on these facilities.

The Department estimates that, for most facilities, the cost of determining and reporting the actual emissions would range from $2,000 to $20,000 per year. These figures are based on informal verbal estimates from workgroup members and are similar to what other state agencies have estimated. These costs include maintaining appropriate records of operation, staff resources to fill out and submit the emission statements, and possibly computer equipment and software to manage the data needed to submit the emission statement. Generally, the cost to comply with the proposed new rules increases as the number of sources at a facility increases. Factors which would decrease the cost of compliance include the level at which the facility already maintains operating and emission records containing information required to be reported under the proposed new rules, and whether the facility already has qualified staff available to collect and record the required information. Additionally, it is expected that a facility would incur reduced costs in submitting emission statements in the years following its initial submission due to the fact that the mechanisms for reporting would already be in place.

Owners or operators of facilities may choose to modify equipment, add additional control measures or use alternative raw materials or processes to reduce a facility's potential emissions below the level that requires a facility to obtain an operating permit and below reporting thresholds listed at N.J.A.C. 7:27-21.2. In this way, they can avoid being subject to these reporting requirements for the emissions of the subsequent calendar year, and of following years, as long as the facility's potential to emit remains below the reporting thresholds. The costs to such facilities would be the costs they incur in making these modifications.

Environmental Impact

Although subchapter 21 has no direct impact on air contaminant emissions, the Department expects the implementation of subchapter 21 to have an indirect positive effect on the environment. The proposed amendments would provide information from additional facilities which would improve the Department's ability to track progress toward attainment of the NAAQS for ozone and to develop regulatory strategies with the most environmental impact for the least economic cost. Up to date and accurate inventory and database management will allow better tracking of VOC, NO_X, SO_2, TSP, PM_{10}, Pb and CO emissions from the regulated facilities. This will result in a more effective regulatory program in New Jersey.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has determined that these proposed amendments would impose additional reporting and recordkeeping requirements on small businesses. Small businesses are defined by the Regulatory Flexibility Act as "any business which is a resident in this State, independently owned and operated and not dominant in its field, and which employs fewer than 100 full time employees." These amendments would affect those small businesses which are not subject to the current emission statement rules and which would be subject to the rules when these proposed amendments are adopted. The Department estimates that approximately 20 additional small businesses would be subject to the emission statement rules when the proposed amendments are adopted. As discussed in the Economic Impact statement above, the Department estimates that small businesses will incur annual costs of $2,000 to $20,000 to collect the required information, submit the emission statements, and maintain the required records.

Many of the small businesses subject to this rule have relatively large potentials to emit air contaminants. And the Department cannot exempt small businesses from the requirements of subchapter 21, or limit their obligations under subchapter 21, while complying with the mandate of the CAA which does not provide the Department with the latitude to establish different requirements for small businesses. However, the Department has provided some flexibility in the reporting requirements that are available to small businesses. For example, small source operations may be reported at a lower level of detail. Also, for some source operations, the Department may calculate the actual emissions based on the operating data provided and standard emissions factors. These amendments would also allow small businesses (as well as other facilities) to request for an extension to submit an emission statement at a later date.

References

(1) Cody, R.P., Weisel, C.P., Birnbaum, G., and Lioy, P.J., "The Effect of Ozone Associated with Summertime Photochemical Smog on the Frequency of Asthma Visits to Hospital Emergency Departments." Environmental Research, 1992.

(2) United States Environmental Protection Agency, "National Air Quality Trends Report, 1990." November 1991.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:27-21.1 Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

. . .

"Federally enforceable" means all limitations and conditions on operation, production, or emissions which can be enforced by EPA pursuant to authorities which include, but are not limited to, those established in:

1.-2. (No change.)

3. Any provision of an applicable State Implementation Plan; [or]

4. Any permit issued pursuant to the requirements established at 40 CFR 52.21; 40 CFR 51, Subpart I; 40 CFR 70; or 40 CFR 71; or [N.J.A.C. 7:27]

5. Any permit or order issued pursuant to requirements established under the Air Pollution Control Act, N.J.S.A. 26:2C-1 et seq., and this chapter.

. . .

"Operating permit" means a permit issued by the Department pursuant to N.J.A.C. 7:27-22 to authorize the use of one or more source operations from which air contaminants may be emitted.

"Order" means any and all orders issued by the Department including, but not limited to, Administrative Orders and Administrative Consent Orders.

. . .

"Potential to emit" means the [capability] **maximum aggregate capacity** of a source operation or of a facility to emit an air contaminant [at maximum] **under its physical and operational** design [capacity, except as constrained by any federally enforceable condition. Such federally enforceable conditions may include, but are not limited to, the effect of installed control apparatus, restrictions on the hours of operation, and restrictions on the type or amount of material combusted, stored, or processed]. **Any physical or operational limitation on the capacity of a source operation or a facility to emit an air contaminant, including control apparatus, and restrictions on hours of operation or on the type or amount of material combusted, stored or processed, shall be treated as part of its design if the limitation is Federally enforceable.**

"Preconstruction permit" means a "Permit to Construct, Install or Alter Control Apparatus or Equipment" issued by the Department pursuant to N.J.S.A. 26:2C-1 et seq., in particular N.J.S.A. 26:2C-9.2, and implementing rules at N.J.A.C. 7:27-8.

. . .

"USC" means the United States Code.

. . .

7:27-21.2 Applicability

(a) Any owner or operator of a facility is subject to the requirements of this subchapter for any calendar year in which the facility emits or has the potential to emit, directly or indirectly to the outdoor atmosphere, any air contaminant listed at Table 1 at a rate greater than or equal to the applicable threshold. Emission statements are required[, starting for the 1992 calendar year, for any air pollutant exceeding the thresholds in Table 1] **to be submitted by a facility if the facility has the potential to emit any of the air contaminants listed at Table 1 during the calendar year indicated in the table or any calendar year thereafter.**

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TABLE 1
AIR CONTAMINANT REPORTING THRESHOLDS

Air Contaminant	Threshold in Tons per Year	**Beginning Calendar Year**
VOC	10	**1992**
NO_x	25	**1992**
CO	100	**1992**
SO_2	100	**1993**
TSP	100	**1993**
PM_{10}	100	**1993**
Pb	5	**1993**

(b) Notwithstanding the provisions of (a) above, an owner or operator of a facility is subject to the requirements of this subchapter if the facility is required to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)1 through 5 and (b) or if the facility elects to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)6 and (d) and shall annually submit an emission statement pursuant to this subchapter for the emissions occurring during 1993 and thereafter.

[(b)](c) (No change in text.)

[(c) Notwithstanding (a) above, no facility is required, pursuant to this subchapter, to submit an emission statement for SO_2, TSP, PM_{10}, or Pb with respect to emissions occurring in or before 1992.]

(d) (No change.)

7:27-21.3 General provisions

(a) [Except as provided in N.J.A.C. 7:27-21.2(b), each] **Each** owner or operator of a facility shall submit to the Department an emission statement pertaining to the emissions released directly or indirectly into the outdoor atmosphere during any calendar year in which the facility is subject to this subchapter pursuant to N.J.A.C. 7:27-21.2. [Such] **If a facility is required to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)1 through 5 and (b) or if a facility elects to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)6 and (d), such emission statement shall include information for all air contaminants listed in Table 1. If a facility is not required to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)1 through 5 and (b) or does not elect to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)6 and (d), such** emission statement shall include information only for the air contaminant(s) for which the facility's potential to emit equals or exceeds the applicable thresholds set forth in N.J.A.C. 7:27-21.2 Table 1; however, if the facility's potential to emit equals or exceeds the reporting threshold for VOC, NO_x, or CO, the facility must report information for VOC, NO_x and CO.

(b) The owner [and] **or** operator of any facility subject to this subchapter shall be responsible for ensuring compliance with all requirements of this subchapter. Failure to comply with any provision of this subchapter shall subject the owner [and] **or** operator to civil penalties in accordance with N.J.A.C. 7:27A-3 and applicable criminal penalties including, but not limited to, those set forth at N.J.S.A. 26:2C-19(f)1 and 2. All owners and operators are jointly and severally liable for such civil and criminal penalties.

(c)-(f) (No change.)

7:27-21.4 Procedure for submitting an emission statement

(a) Emission statements shall be submitted to the Department on or before:

1. [May 31, 1993 for a facility applicable to this subchapter due to the emissions of 1992; and

2. For each following year,] April 15 of each calendar year following any calendar year in which the facility is subject to this subchapter; **or**

2. The date approved by the Department pursuant to N.J.A.C. 7:27-21.8.

(b)-(c) (No change.)

(d) Any person submitting an emission statement shall transmit the report to the Department on paper. With the written prior approval of the Department, an emission statement may be submitted on computer diskette or electronically, in a form approved by the Department, in lieu of a submission of an emission statement on paper. Notwithstanding this subsection, certification in accordance with the provisions of N.J.A.C. [7:27-8.24 as required in this subchapter] **7:27-21.7** shall accompany any transmission of an emission statement to the Department.

(e) (No change.)

7:27-21.5 Required contents of an emission statement

(a) (No change.)

(b) Emission statements shall include the following facility identification information:

1.-8. (No change.)

9. Plant contact; [and]

10. Plant contact phone number[.]; **and**

11. If a facility is required to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)1 through 5 and (b) or if a facility elects to obtain an operating permit pursuant to N.J.A.C. 7:27-22.2(a)6 and (d), the number of pieces of equipment which are significant source operations or parts of significant source operations as specified at N.J.A.C. 7:27-22.6(c) through (e).

(c)-(h) (No change.)

(i) The following information may replace the more detailed information required at (c) through (h) above only for any source operation which has the potential to emit less than 0.1 ton per year of Pb or less than one ton per year of any other air contaminant required to be reported pursuant to this subchapter:

1. The following information shall be supplied:

i.-ii. (No change.)

iii. Code [10] **11** from Table 2 below; or

2. (No change.)

(j)-(k) (No change.)

(l) The method used for quantifying actual emissions for a source operation for use in preparing emission information required in (d)1, (f)1, (h)1 or (i)2 above shall be the method from Table 2 which is reasonably available and which the reporting entity believes best estimates the actual emissions from the source operation, unless **a method specified in** an operating permit pursuant to [Title V of the Federal Clean Air Act] **N.J.A.C. 7:27-22** has been issued by the Department for the facility. In such case, the method used shall be the method specified in the operating permit.

TABLE 2

CODES FOR METHODS OF QUANTIFYING ACTUAL EMISSIONS

Method	**Code**
Emissions based on Continuous Emission Monitoring	1
Emissions based on source test or other measurements	2
Emissions based on material balance using engineering knowledge of the process	3
Emissions based on AP-42	4
Emissions based on best engineering judgment	5
Emissions based on a state or local agency's emission factor	6
New construction not yet operational; emissions are zero	7
Source closed, operation ceased	8
Emissions to be computer calculated by the Department or EPA based on standard emission factor (SCC emission factor file)	9†
Emissions to be computer calculated by the Department or EPA based on other approved emission factor	10†
Emissions estimated at one ton per year (0.1 ton per year for Pb)	11‡

†Codes [8] **9** and [9] **10** may only be used for selected source operations with prior notice or approval from the Department.

‡Code [10] **11** may only be used for source operations which meet the criteria to report pursuant to (i)1 above.

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TABLE 3

CONTROL APPARATUS IDENTIFICATION CODES

(No change.)

7:27-21.8 Request for extensions

(a) A responsible official who is unable to submit an emission statement pursuant to this subchapter by the due date may request an extension to submit an emission statement.

(b) A request for an extension shall include the following information:

1. The Air Pollution Control Plant Identification Number of the facility (if one exists);

2. The plant contact and telephone number;

3. The name and telephone number of the responsible official;

4. The reasons and justifications for the inability to submit the emission statement by the due date and the extreme hardship that would be prevented by submitting the emission statement after the due date; and

5. The date by which the responsible official commits to submit the emission statement which can be no later than one month from the due date.

(c) A request for an extension shall be submitted, in writing, to the following address:

Chief, Bureau of Air Quality Planning
Department of Environmental Protection and Energy
CN 418
Trenton, NJ 08625-0418
ATTN: Emission Statements—Extension Request

(d) The Department recommends that an initial request for an extension be submitted by April 1. The Department will not consider an initial request for an extension if the Department receives it after April 15.

(e) A responsible official may request one additional request for an extension as long as the Department receives it before the initial extension has expired.

(f) Within 10 working days after receipt of a request for extension, the Department will respond with its determination as to whether the request for extension is denied or granted and the date by which the emission statement is due. The Department will grant an extension if the extension is necessary to prevent extreme hardship.

(g) A request for an extension shall be automatically granted if all of the following conditions are met:

1. The Department receives a request for an extension from the responsible official by the date set forth in (d) above for an initial request or in (e) above for an additional request;

2. The date that the responsible official commits to submit the emission statement is no later than one month after the due date as set forth in (b)5 above; and

3. The Department does not respond within 10 working days of receipt of the request.

7:27-21.9 Notification of non-applicability

(a) If conditions at a facility have changed in a manner such that a facility which was required to submit an emission statement in the previous year is not required to submit an emission statement in the current year, the responsible official shall notify the Department in accordance with this section. The responsible official shall submit such notification of non-applicability to the Department by February 1 of the first year in which the facility is not required to submit an emission statement.

(b) A notification of non-applicability must include the following information:

1. The plant ID of the facility;

2. The plant contact and telephone number;

3. The name and telephone number of the responsible official;

4. The reasons and justifications as to why the responsible official believes that the facility is not required to submit an emission statement pursuant to N.J.A.C. 7:27-21.2 including, but not limited to, the following:

i. The maximum annual quantity of air contaminants allowed to be emitted from all sources pursuant to each preconstruction permit held by the facility at any time during the year;

ii. The maximum annual quantity of air contaminants that can be emitted from all source operations at their maximum design capacity that are not subject to a preconstruction permit;

iii. The maximum annual quantity of all air contaminants that can be emitted as fugitive emissions; and

iv. Whether the facility is required to obtain or has voluntarily applied for an operating permit pursuant to N.J.A.C. 7:27-22; and

5. A statement as to whether the owner or operator anticipates that conditions at the facility may change in a manner that the facility may in future years be required to submit an emission statement pursuant to N.J.A.C. 7:27-21.2.

(c) A notification of non-applicability shall be submitted to the following address:

Chief, Bureau of Air Quality Planning
Department of Environmental Protection and Energy
CN 418
Trenton, NJ 08625-0418
ATTN: Emission Statements—Notification of Non-applicability

(d) By April 1, the Department shall respond with its determination as to whether the Department concurs with the responsible official's statement that the facility is not required to submit an emission statement. Failure of the Department to meet this deadline does not relieve the facility's responsibility to comply with all applicable provisions of this subchapter nor does it constitute the Department's concurrence with the responsible official's statement that the facility is not required to submit an emission statement.

(e) If a notification of non-applicability is received by the Department after February 1, the Department is under no obligation to respond to the notification and may take enforcement action pursuant to N.J.A.C. 7:27A-3.10 if the facility does not submit an emission statement pursuant to this subchapter and the Department determines that the facility was required to do so.

7:27[21.8]**21.10** (No change in text.)

7:27A-3.10 Civil administrative penalties for violations of rules adopted pursuant to the Act

(a)-(d) (No change.)

(e) The Department shall determine the amount of the civil administrative penalty for offenses described in this section on the basis of the provision violated and the frequency of the violation. Footnotes 3, 4, and 8 set forth in this subsection and (f) below are intended solely to put violators on notice that in addition to any civil administrative penalty assessed the Department may also revoke the violator's operating certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an operating certificate or variance, but merely indicate the situations in which the Department is most likely to seek revocation. The number of the following subsections corresponds to the number of the corresponding subchapter in N.J.A.C. 7:27.

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1.-20. (No change.)

21. The violations of N.J.A.C. 7:27-21, Emission Statements, and the civil administrative penalty amounts for each violation are as set forth in the following table:

Citation	Class	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-21.4(a)	Failure to Submit	$2000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-21.5(a)	Failure to Certify	[$1,000]**$2,000**	[$2,000]**$4,000**	[$5,000]**$10,000**	[$15,000]**$30,000**
N.J.A.C. 7:27-21.5(b)-(k)	Omission of Required Information	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-21.6(a)	Failure to Keep Records	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-21.6(b)	[Readily Available] **Records Availability**	[$100]**$500**	[$200]**$1,000**	[$500]**$2,500**	[$1,500]**$7,500**
N.J.A.C. 7:27-21.9(a)	**Failure to Submit Notification of Non-applicability**	**$100**	**$200**	**$500**	**$1,500**

22.-25. (No change.)

(a)

OFFICE OF AIR QUALITY MANAGEMENT

Control and Prohibition of Air Pollution By Vehicular Fuels (Oxygenated Fuel)

Proposed Amendments: N.J.A.C. 7:27-25.1, 25.3, 25.4, 25.10, 25.11 and 25.12, and N.J.A.C. 7:27A-3.10

Proposed Repeal: N.J.A.C. 7:27-25.9

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1B-3 and 26:2C-1 et seq., in particular 26:2C-8.

DEPE Docket Number: 44-93-08/200.

Proposal Number: PRN 1993-471.

A **public hearing** concerning this proposal will be held on:

Friday, September 24, 1993, at 10:00 A.M.
First Floor Hearing Room
Department of Environmental Protection and Energy
State of New Jersey
401 East State Street
Trenton, New Jersey

Submit written comments, identified by docket number given above, by October 7, 1993 to:

Janis Hoagland, Administrative Practice Officer
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

Copies of this notice and of the proposed amendments are being deposited and will be available for inspection during normal office hours until October 7, 1993, at:

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Northern Regional Office
1259 Route 46, Bldg. #2
Parsippany, New Jersey 07054

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Southern Regional Office
20 East Clementon Road, 3rd Floor North
Gibbsboro, New Jersey 08026

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Central Regional Office
Horizon Center, Building 300
Route 130
Robbinsville, New Jersey 08691

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Metropolitan Regional Office
2 Babcock Place
West Orange, New Jersey 07052

These amendments will become operative 60 days after adoption by the Commissioner (See N.J.S.A. 26:2C-8).

The agency proposal is set forth below. It contains six major components: a "Summary" section which describes the purpose and scope of the proposal, a "Social Impact" section which describes the anticipated societal effects of the proposal, an "Economic Impact" section which sets forth the anticipated costs and benefits of the proposal, an "Environmental Impact" section which sets forth the anticipated emission reductions to be obtained, a "Regulatory Flexibility Analysis" section which examines the effect of the proposal on small businesses, and a full statement of the text of the proposed amendments and repeal. The footnotes referenced throughout (as, for example, [1]) may be found after the "Regulatory Flexibility Analysis" section.

Summary

The New Jersey Department of Environmental Protection and Energy (the Department) is proposing to amend and repeal portions of N.J.A.C. 7:27-25 (subchapter 25), Control and Prohibition of Air Pollution from Vehicular Fuels. Subchapter 25 governs the volatility and the oxygen content standards in gasoline. The proposed amendments to subchapter 25 establish a shorter oxygenated gasoline control period for the Northern oxygen program control area, defined as the control area including the counties of Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, and Warren. It is important to note, however, that the proposed reduction in the control period for these northern New Jersey counties is contingent upon approval by the United States Environmental Protection Agency (EPA), which has been formally requested in a letter petition from DEPE to reduce the northern oxygen program control period. In accordance with the Clean Air Act Amendments of 1990, specifically, 42 U.S.C. 7545(m)(2) (Section 211(m)(2)), EPA is charged by Congress with designating control areas and control periods for the oxygenated fuel program nationwide and, therefore, is the agency which rules on state petitions to alter those designations. (Further discussion of this proposed change follows later in this summary.)

Should the EPA deny DEPE's petition for a reduced control period for its northern counties, the Department will not adopt the proposed amendment to N.J.A.C. 7:27-25.3(c), thereby retaining the control periods currently set forth at N.J.A.C. 7:27-25.3(c)1i and ii.

As the Department has not yet had a response to its petition to EPA concerning the proposed reduction of the control period, it is unlikely

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that these amendments will be adopted in time to obviate the need for oxygenated fuel this October. It will be adopted in time, however, to be able to take advantage of the shortening of the period in spring, 1994. Absent EPA's approval, the Department will not revise the control period.

The proposed repeal of the variance for contemporaneous averaging section, N.J.A.C. 7:27-25.9, would eliminate the option currently extended to gasoline retailers or wholesale purchaser-consumers to comply with the oxygen content standard in gasoline through contemporaneous averaging.

The proposed amendments to subchapter 25 also revise the recordkeeping and reporting requirements to which refiners, importers, blenders, distributors, wholesale purchaser-consumers and retailers who provide gasoline for use in New Jersey are subject. Specifically, the proposed amendments require that refiners, importers, blenders or distributors document and report only information pertaining to the category and not the specific species of oxygenate present in gasoline, as is currently required. Further, the proposed amendments add the requirement that these refiners, importers, blenders, or distributors inform the retail outlet or wholesale purchaser-consumer facility as to the category of oxygenate being used in the gasoline by certifying to those entities the category of oxygenate present in the gasoline being transferred. The proposed amendments also add the Grabner test method to those test methods currently approved for use in determining the Reid vapor pressure (RVP) in gasoline.

The Department is also proposing related amendments at N.J.A.C. 7:27A-3.10, Civil administrative penalties and requests for adjudicatory hearings, consistent with repeal of the variance for contemporaneous averaging section and the recodification of the sections following it.

On October 5, 1992, N.J.A.C. 7:27-25 was amended to adopt the oxygenated fuels program mandated by the Clean Air Act (CAA), 42 U.S.C.A. §7401 et. seq., as amended by the Clean Air Act Amendments of 1990 (CAAA), Pub.L. 101-549, November 15, 1990.[1] The oxygenated gasoline requirements were established to reduce emissions of carbon monoxide (CO) from motor vehicles. CO is generally a localized wintertime pollutant. Elevated levels of CO are associated both with congested traffic and with colder temperatures, when motor vehicles tend to burn fuel less efficiently. The adoption of the oxygenated fuels program represents one component of a broader initiative undertaken by the Department to attain the National Ambient Air Quality Standard (NAAQS) for CO.

The oxygenated fuels program sets standards for the oxygen content of motor vehicle fuel. These standards require gasoline for use in New Jersey to contain a minimum of 2.7 percent by weight oxygen content during the time of the year when areas of New Jersey are prone to exceed the NAAQS for CO. These amendments to subchapter 25 became effective November 1, 1992, and are expected to be approved by EPA as an amendment to New Jersey's State Implementation Plan (SIP) for the attainment and maintenance of the NAAQS for CO.

The Department is proposing amendments to N.J.A.C. 7:27-25 at this time. The proposed amendments to N.J.A.C. 7:27-25.3 revise the oxygenated gasoline control period (control period) for the Northern Air Quality Control Region (AQCR) in New Jersey. The Department has submitted a petition to the EPA requesting approval to shorten the oxygenated gasoline control period for Northern New Jersey from seven months, October 1 through April 30, to four months, November 1 through February 28, based on more recent monitored meteorological data than was relied upon by EPA when it originally designated the seven month control period for this area in 1992. This petition does not affect Southern New Jersey, for which the minimum oxygenated gasoline control period of four months has already been established by N.J.A.C. 7:27-25.3.

On October 20, 1992, EPA published its final guidance on the establishment of the states' oxygenated gasoline control periods.[6] In this notice, EPA established a seven month control period for the New York-New Jersey-Connecticut Consolidated Metropolitan Statistical Area (New York-Northern New Jersey-Long Island CMSA) and a four month control period for the Pennsylvania-New Jersey-Delaware-Maryland CMSA (Philadelphia-Wilmington-Trenton CMSA). For a more detailed discussion of the determination and establishment of the control period for New Jersey, refer to the Department's proposal of the oxygenated fuels program set forth in the July 6, 1992 New Jersey Register.[7]

Section 211(m)(2) of the Act requires EPA to establish control periods based on the portion of the year an area is "prone" to high ambient concentrations of CO. This section also allows a state to request, with respect to any area designated as nonattainment for CO, a reduced control period for the oxygenated gasoline program. The Act states that the approval of the EPA is contingent upon the requesting state's demonstration, based on meteorological conditions, that a reduced control period will not result in exceedances of the NAAQS for CO outside the reduced control period.

By letter petition from Commissioner Scott A. Weiner to EPA Region II Acting Regional Administrator Muszynski dated June 21, 1993, the Department requested EPA to modify its requirement that oxygenated gasoline be sold in Northern New Jersey for seven months, October 1 through April 30 by reducing the control period to four months, November 1 through February 28. The petition was submitted to EPA based upon monitored meteorological data from 1990 to the present which the Department believes justifies such a reduction in the control period for Northern New Jersey. The data show that the highest concentrations of CO in the northern New Jersey counties occur during the four-month period from November through February of each data year. In addition, there have been no exceedances of the federal health standard for CO during the months of October, March and April in Northern New Jersey since 1990. Therefore, the Department has requested that the control period for Northern New Jersey be reduced to the four month period. The Department anticipates that the shortened control period will maintain sufficient reduction in CO emissions to enable the State to meet the NAAQS for CO while minimizing the financial impact of the oxygenated fuels program on New Jersey residents. As stated earlier in this proposal, however, the adoption of the proposed amendment to shorten the oxygenated gasoline control period for the Northern control area set forth at N.J.A.C. 7:27-25.3 will depend upon EPA's response to the Department's petition.

All sections of the adopted rules became operative on November 1, 1992 with the exception of N.J.A.C. 7:27-25.9, Variance for contemporaneous averaging. The Department chose to delay the operative date of the contemporaneous averaging section until May 1, 1993, because of the questions raised during the public comment process. The Department, therefore, extended the public comment period to further consider the effect of adopting this section. The comment period opened on October 5, 1992 and closed on January 30, 1993.

In the adoption document for the oxygenated gasoline program,[1] the Department committed to publishing a miscellaneous notice in the New Jersey Register (N.J.R.) which, would set forth its decision, based upon review of any additional comment received, to either establish May 1, 1993 as the binding operative date for this section or to extend the operative date further until promulgation of the proposed repeal or amendment of this section. On June 21, 1993, the Department published the miscellaneous notice in the N.J.R. to inform the regulated community and other interested persons of its proposed action.[2]

After reviewing and considering the additional comments received during the extended comment period, the Department has decided to propose a repeal of the variance for contemporaneous averaging provision currently set forth at N.J.A.C. 7:27-25.9. The Department's decision to propose this repeal was based on the following:

Only one company, Mobil Oil Corporation, responded in writing to the Department's invitation to comment on the contemporaneous averaging provision. Mobil recommended the repeal of this provision, arguing that this provision is discriminatory, favoring ethanol blends, and that it may lead to less effective enforcement.[3] In response, the Department does not concur that the program would have unfairly favored ethanol blenders, nor would it have presented an enforcement problem. However, based on these and other comments received, both in the initial and supplemental comment periods, the Department has decided to repeal this provision, making further consideration of these comments unnecessary.

In order to gain a better understanding of the effect of adopting this section, the Department also conducted an informal survey of the regulated community, including those persons who commented during the public comment period for the original rule proposal and those who would potentially be impacted by the contemporaneous averaging provision, that is, the refiners, importers, blenders, distributors, wholesale purchaser-consumers and retailers that conduct business in New Jersey.

In response to this survey, only one company expressed any interest in using this averaging provision, and only if it also chose to use Pennsylvania's credit averaging program as well. As no other petroleum marketers chose to utilize Pennsylvania's credit averaging mechanism to meet the oxygen content requirements of gasoline during the 1992-1993

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control, the Department conjectures that Pennsylvania's averaging option is not perceived as economical by the industry as a whole.

It should be noted that none of the neighboring states except for Pennsylvania have adopted the credit averaging program developed by EPA. Maryland, Connecticut and New York, the states which share the oxygenated fuels program with New Jersey, chose to adopt a non-averaging, per gallon, program to comply with the CAAA mandates.

Additionally, in responding to the Department's informal survey, the Fuel Merchants Association, British Petroleum Company, and the New Jersey Gasoline Retailers Association, reaffirmed their opposition to the contemporaneous averaging provision originally voiced during the comment period for the rule proposal.[4]

After careful consideration and review of the above mentioned comments concerning the potential impact of retaining this averaging provision, as well as the comments received during the original public comment period for this rule, the Department is proposing to repeal N.J.A.C. 7:27-25.9, Variance for contemporaneous averaging.

The Department is also proposing amendments to N.J.A.C. 7:27-25.4, the recordkeeping and compliance section, as it pertains to the oxygenated fuels requirements in subchapter 25. The recordkeeping requirements are being revised to address EPA's letter to the states[8] recommending that gasoline terminal operators be provided with some flexibility when providing information to distributors on transfer documents regarding the oxygenate type included in the fuel leaving the terminal. The Department has reviewed this letter of recommendation and has worked with the regulated parties in developing proposed amendments.[9]

The proposed amendments to N.J.A.C. 7:27-25.4 add the Grabner test method to the list of approved tests for measuring RVP in gasoline. This new method was recently approved by EPA in a Federal Register notice dated March 17, 1993[10]. The Shell Oil Company requested the Department's approval for use of the Grabner method so that it would not be required to use two tests in order to comply with both Federal and State RVP regulations.[11] The Department internally reviewed the pertinent information concerning this new test method[12] and is hereby proposing to adopt the Grabner method as part of its acceptable RVP test methods.

A detailed summary of the proposed repeal and amendments follows:

N.J.A.C. 7:27-25.3 General provisions

N.J.A.C. 7:27-25.3(c) currently requires oxygenated fuels to be used from October 1 through April 30 in the Northern control area and from November 1 through February 28 in the Southern control area. The proposed amendments to N.J.A.C. 7:27-25.3(c) will establish a uniform four month control period Statewide, thereby shortening the oxygen program control period in the Northern control area to four months, November 1 through February 28. The final adoption of this uniform, shortened control period is therefore contingent upon approval by EPA. As a result of this proposed amendment, the Department is proposing several related amendments necessitated by a uniform four month control period Statewide. Specifically, the Department proposes to delete the definition of "northern oxygen program control area" and "southern oxygen program control area" set forth at N.J.A.C. 7:27-25.1 and instead proposes a new definition "oxygen program control area" which specifies that there will be one control area for the entire geographic area of the State. In a related fashion, the Department proposes to amend slightly the definition of "oxygen program control period" which would also be uniform throughout the State. The final related amendment modifies N.J.A.C. 7:27-25.3(f)1i to delete the references to northern and southern oxygen program control areas which are being replaced with the new definition as explained above.

The Department has proposed this amendment while it awaits final word from EPA regarding its petition to shorten the northern control period. Without this approval, amendment of the oxygenated gasoline control period provision will not be adopted, thereby leaving the existing control periods in place.

Under the proposed amendments to N.J.A.C. 7:27-25.3(g), retailers will no longer be required to inform consumers as to the specific species of oxygenate type (for example, ethanol or MTBE) used in the gasoline sold. Instead, the proposed amendments require only that retailers inform consumers as to the general category of oxygenate, either alcohol or ether blends.

N.J.A.C. 7:27-25.4 Recordkeeping and compliance determinations

Currently, N.J.A.C. 7:27-25.4(a) requires that each refiner, importer, blender or distributor certify certain information to distributors, retailers, or wholesale purchaser-consumers, but the regulation does not require that they certify the oxygenate type on the invoice, bill of lading, or other such transfer document. The proposed amendments to N.J.A.C. 7:27-25.4(a) will require this information to be certified on the transfer document so that retailers will have the information necessary to comply with the proposed amendment to N.J.A.C. 7:27-25.3(g), requiring them to inform consumers of the category of oxygenate present in the fuel sold.

As promulgated on October 5, 1992, N.J.A.C. 7:27-25.4(a)3 requires records to be maintained on the type, percent by volume, and oxygen content percent by weight of each oxygenate which comprises one percent or greater by volume in the gasoline. The proposed amendment will revise N.J.A.C. 7:27-25.4(a)3 to require that refiners, importers, blenders, or distributors maintain records on the oxygen content weight percent and the category of oxygenate used in the gasoline. (For example: "the oxygen content is 2.7-2.9 percent by weight with ethers" or "oxygen content is 2.7-3.5 percent by weight with alcohols").

N.J.A.C. 7:27-25.4(b) currently requires that retailers or wholesale purchaser-consumers keep records on the specific species of oxygenate type. The proposed amendment to N.J.A.C. 7:27-25.4(b) will require that retailers or wholesale purchaser-consumers maintain records on the category and oxygen content percent by weight of oxygenate used in the delivered fuel, in a manner consistent with that required of their distributors.

The proposed amendment to N.J.A.C. 7:27-25.4(d) adds the Grabner method to the Department's list of approved RVP test methods as further explained above.

N.J.A.C. 7:27-25.9 Variance for contemporaneous averaging

As explained earlier, the Department is proposing to repeal the entire section. Remaining sections of the subchapter will be recodified to reflect repeal of this section.

N.J.A.C. 7:27A-3.10 Penalties

The Department is proposing to repeal certain penalties set forth at N.J.A.C. 7:27A-3.10 so as to eliminate those administrative penalties to which persons utilizing the variance for contemporaneous averaging section, N.J.A.C. 7:27-25.9 would be subject. The Department then proposes to recodify the penalties associated with Variance for Shortage of Supply which will become N.J.A.C. 7:27-25.9 based on the proposed repeal of the averaging provision currently occupying that section.

Recodification of Existing Sections of Subchapter 25

For organizational clarity, the following table lists the rule sections and their location as a result of the proposed repeal and amendments.

Rule Section		Action	Proposed New Section	
25.10	Variance for shortage of supply	Recodify	25.9	Variance for shortage of supply
25.11	Owner and operator responsibility	Recodify	25.10	Owner and operator responsibility
25.12	Service fees	Recodify	25.11	Service fees

Social Impact

The proposed amendments and repeal will have a positive social impact on the State. The oxygenated fuels program, which this rulemaking modifies, is designed to help New Jersey achieve and maintain the NAAQS for CO by reducing the emissions of CO from motor vehicles. The modifications to the program proposed herein will allow for a smoother operation of the same, without significantly impacting the effectiveness of the program. The program will continue to reduce or prevent the exposure of millions of persons who reside or work in New Jersey to unhealthy ambient concentrations of CO. These modifications reflect the Department's continued effort to promulgate sound and effective regulations in order to achieve necessary emission reductions by the State to meet the Federal health standards for CO.

The proposed reduction in the oxygenated gasoline control period for the Northern control area in New Jersey, if ultimately approved by EPA and then adopted by the Department, will assist gasoline suppliers in meeting both the oxygen content requirements and the volatility standards for gasoline as set forth at N.J.A.C. 7:27-25.3. Currently, New Jersey's oxygenated fuels program requires that gasoline contain a minimum of 2.7 percent oxygen content by weight starting October 1 through April 30 in the Northern control area in New Jersey. The

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volatility standards require that the RVP of gasoline be no greater than 9.0 pounds per square inch (psi) for use in New Jersey from May 1 through September 15.

The gasoline suppliers using alcohol blends such as ethanol to meet the oxygenated fuels requirements have found it difficult to be in compliance with the RVP standards by May 1. The use of ethanol as a blending agent in gasoline tends to increase the RVP of the gasoline. For further discussion on ethanol blends and the effect of ethanol on RVP, refer to the environmental impact section of the original oxygenated fuels proposal published in the July 6, 1992 N.J.R.[7]. Thus, suppliers of ethanol-blended fuel have requested the Department to allow an adequate transition period between the oxygenated gasoline control period and the RVP control period for appropriate changes to take place so that the fuel meets the RVP requirements. The proposed amendment to reduce the northern control period to four months (November-February) will provide suppliers of ethanol-blended gasoline sufficient time to meet both the oxygenated fuels requirements and the RVP standards effective May 1.

The proposed amendment to N.J.A.C. 7:27-25.3(g) requiring that retailers inform inquiring consumers of the category instead of the specific type of oxygenate in the gasoline being dispensed at the retail facility will also have a positive social impact in that consumers will be able to make better, informed purchase of the fuel, should they have preferences as to the type of oxygenate they wish to use.

The Department is proposing to modify its oxygenated gasoline recordkeeping requirements in response to feedback from the regulated industry that the current recordkeeping requirements are unduly burdensome and can be simplified without diminishing the environmental benefits of the program. The proposed requirements are expected to provide flexibility in documenting information pertaining to the oxygenated type and oxygen content in gasoline.

In a like manner, by proposing to accept the EPA-approved Grabner method in addition to the American Society for Testing and Materials (ASTM) test methods in certifying fuel for use in New Jersey, these amendments will facilitate inter-state exchange and transfer of gasoline.

While the use of oxygenated fuels in motor vehicles is well documented in helping to reduce harmful levels of CO, the Department is concerned about the potential other health effects associated with certain oxygenated fuels. During the past control period, the Department received a number of complaints from the public regarding the use of oxygenates. The complaints were mainly reported by motorists and gas station attendants who stated that they experienced symptoms of nausea, headaches, dizziness, and shortness of breath when primarily exposed to gasoline blended with Methyl Tertiary Butyl Ether (MTBE).

The Department and EPA are aware of this potential health problem and are studying the health effects of MTBE-blended gasoline. The Center for Disease Control (CDC) and the Environmental and Occupational Health Science Institute (EOSHI) are conducting epidemiological studies at this time. The results were presented at an EPA-sponsored symposium on July 26-28, 1993, in Falls Church, Virginia. The Department plans to carefully review the results of these studies. Also, the Department, in conjunction with the Environmental and Occupational Health Science Institute (EOHSI) will sponsor a workshop to discuss both the supply and distribution issues related to this proposal and the health effects studies as presented at the EPA Symposium. This workshop will be held at 10:00 A.M. on Wednesday, September 15, 1993 at the Legislative Services Building, Room 9, West Hanover Street, Trenton, New Jersey. In the event the Department decides to disallow the use of any species of oxygenate, such a decision will be implemented through appropriate rulemaking practice.

Economic Impact

The Department expects that neither the proposed repeal nor the proposed amendments will have an adverse economic impact. In fact, the Department anticipates that the amendments and repeal will provide greater flexibility to the regulated industry while providing a significant cost savings to the public.

Under the current regulation which reflects EPA's designations, the oxygenated fuels program requires the use of oxygenated gasoline for seven months in the northern control area and for four months in the southern control area. As stated in the original proposal document, the Department estimates the cost of producing oxygenated fuel to be between $0.03 to $0.05 per gallon more than the cost of producing conventional fuel.[13] Based on the Department's 1992 sales figures of motor gasoline, this cost differential will account for a savings to New Jersey motorists of between $19 to $32 million if the reduction of the control period for the Northern control area from seven months to four months is approved by EPA and adopted by the Department.

The Department anticipates that the proposed repeal of the variance for contemporaneous averaging provision will not have a negative economic impact on the affected industry or consumers. The Department adopted this provision to provide individuals a market-based approach in meeting the 2.7 percent oxygen content standard. The provision offered flexibility by allowing refiners, importers, and blenders to produce fuel at lower costs by using lesser quantities of oxygenates in the grades of fuel approved by the Department to have a less than 2.7 percent oxygen content, so long as the 2.7 percent standard is met on the average at each retail or wholesale purchaser-consumer's facility.

The Department's decision to propose repeal of this provision is based, in part, on the apparent unanimity of the petroleum industry in its opposition to this averaging provision. Only one refining company expressed any interest at all in utilizing this provision, and that interest was qualified, at that.

The Department anticipates that both the modifications to the recordkeeping requirements and the addition of a new test method will have a positive economic impact. By eliminating the requirement that each shipment of gasoline be tested to identify the specific species of oxygenate(s) used, the proposed change to the oxygen content recordkeeping requirements should result in reduced operational costs for gasoline terminal operators who receive mixed supplies of oxygenated fuel from the pipeline distribution system.

The proposed amendment to add the Grabner method to the Department's list of approved RVP test methods will also result in reduced operating costs for those refiners, importers, blenders, and distributors who may already be using the Grabner method to certify the fuel prior to inter-state shipment of gasoline, as they will no longer be required to use a second method to satisfy the Department's RVP rule.

Environmental Impact

Overall, the proposed amendments and repeal will not have an adverse environmental impact on the State. The use of oxygenated gasoline will continue to improve combustion efficiency and substantially reduce CO emissions from motor vehicles, enabling New Jersey to progress towards attainment of the NAAQS for CO.

Significant air quality benefits have been realized with the implementation of the oxygenated fuels program in New Jersey and nationwide. EPA's Office of Mobile Sources has indicated that there was an 80 percent decline in violations of the NAAQS for CO nationwide during the months of November, 1992, through February, 1993, compared to the previous year when oxygenated fuels were not used. The data provided by the Department's Bureau of Air Monitoring show a drop of approximately 15.0 percent in monitored levels of ambient CO concentrations Statewide during this same period.[14]

The proposed repeal and amendments will not significantly affect the environmental benefits gained by the implementation of this program. The Department recognizes that some emissions reduction will be lost by shortening the oxygenated gasoline control period for the northern control area in New Jersey should EPA allow the Department to adopt a uniform four-month control period for the entire State. However, the Department anticipates that the use of oxygenated fuel during the shortened time period will maintain a sufficient reduction in CO to enable the State to meet the Federal health standard of nine parts per million (ppm) established for CO, which was the original intent and goal of the oxygenated fuels program.

As discussed earlier in the Summary section, the request to EPA to approve a shortened control period is premised on more recent air monitoring data than that originally used by EPA in establishing the seven-month control period. In establishing the control period for an area, EPA used 1988 and 1989 air quality monitoring information to classify areas as either nonattainment (not meeting the NAAQS for CO), or attainment (conforming with the NAAQS for CO). A more detailed discussion of EPA's designations and classifications for New Jersey was published in the New Jersey Register on July 6, 1992, N.J.R.[7]

The Department has reviewed its ambient CO monitoring data for the northern control area during the months of March, April, and October from 1990 through April, 1993. During this period, the highest ambient concentrations of CO measured at the monitoring sites throughout the northern control area for these months was 7.4 ppm at the Elizabeth and North Bergen monitoring sites. Since the highest recorded concentrations fall well below the 9.0 ppm NAAQS for CO and no CO

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exceedances have been recorded for the months of March, April, and October since 1990, the Department contends that the monitored meteorological conditions demonstrate that the northern control area is not "prone" to elevated CO concentrations.

Neither the proposed repeal of the variance for contemporaneous averaging provision nor the proposed amendment to adopt the Grabner test method will have an adverse impact on the environment. The Department adopted the variance for contemporaneous averaging provision to allow the regulated community flexibility in meeting the oxygenated gasoline requirements through a market-based approach. It was anticipated that very few people would consider using this alternative method for compliance so that there would be little impact on the CO emissions reductions achieved by the implementation of the non-averaging, per gallon program. Likewise, eliminating this provision will have little environmental impact on the program, if any. Similarly, the Department expects that the new test method will actually improve the testing procedures to ensure that all gasoline during the program season conforms with the oxygen content standards set forth in N.J.A.C. 7:27-25.3.

The Department expects that the proposal to repeal and amend subchapter 25 will not hinder the State's efforts to come into attainment of the NAAQS standard for CO by January 1, 1995, and be able to maintain this attainment thereafter.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has determined that the proposed repeal and amendments will not impose significant additional recordkeeping, reporting, or other compliance requirements on small businesses as defined in the Regulatory Flexibility Act. In fact, the amendments and repeal require less specific recordkeeping and reporting of the regulated industry than previously required.

Although the proposed amendments will modify the existing recordkeeping requirements, the information proposed to be recorded and maintained is similar in kind to the existing recordkeeping requirements. The additional expense of complying with the proposed certification requirements on the transfer documents is expected to be minimal since the information required on these documents is already being maintained. Thus, it will not be necessary to fill out any additional forms or paperwork to comply with the new requirements. Therefore, no exemption of small business from coverage is provided.

REFERENCES

1. New Jersey Register (N.J.R.), Monday, October 5, 1992 (24 N.J.R. 3539(a)).
2. N.J.R., Monday, June 21, 1993 (25 N.J.R. 2720(a)).
3. Letter dated January 25, 1993, from William K. Vehrs, Environmental Advisor, Mobil Oil Corporation to Richard McManus, Esq., Administrative Practice Officer, Department of Environmental Protection and Energy commenting on "N.J.A.C. 7:27-25.9, Contemporaneous Averaging."
4. 24 N.J.R. pp. 3547-3548.
5. Letter dated June 21, 1993, from Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy to Acting Administrator William Muszynski, P.E., Environmental Protection Agency, Region II for a reduced oxygenated gasoline control period in Northern New Jersey.
6. Federal Register (FR), Volume 57, No. 203, Tuesday, October 20, 1992, pp. 47853-47855.
7. N.J.R., Monday, July 6, 1992 (24 N.J.R. 2386(a)).
8. Memorandum from Mary T. Smith, Director, Field Operations and Support Division to All Parties Interested in Implementation of the Oxygenated Gasoline Provision of the Clean Air Act.
9. Letter dated February 8, 1993, from Donald Patterson, Assistant Director, Office of Air & Environmental Quality to James Benton, Director, New Jersey Petroleum Council on agreement of terms between the New Jersey Petroleum Council and the Department regarding New Jersey's oxygenated fuels requirements.
10. FR. Vol. 58, No. 50, Wednesday, March 17, 1993, p. 14476.
11. Letter dated April 5, 1993, from D.P. Feist, Shell Oil Company to Donald Patterson, Assistant Director, Office of Air & Environmental Quality on "New Jersey RVP Regulations—Test Methods".
12. Memo dated April 20, 1993, from Eric Rau, Ph.D., Assistant Director, Laboratories & Quality Assurance to Donald Patterson, Assistant Director, Office of Air & Environmental Quality on "Evaluation of Grabner method for the determination of Reid Vapor Pressure in gasoline samples".
13. 24 N.J.R. pg. 2390
14. "1993 Carbon Monoxide Air Quality Report" New Jersey Department of Environmental Protection and Energy, March, 1993.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 7:27-25.9.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:27-25.1 Definitions

Words and terms when used in this subchapter, have meanings as defined at N.J.A.C. 7:27-1.4 or as follows, unless the context clearly indicates otherwise.

...

["Northern oxygen program control area" means the control area which includes the counties of Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, and Warren.]

...

"Oxygen program control area" means the entire geographic area within the State of New Jersey.

"Oxygen program control period" means [a] **the** control period in New Jersey during which oxygen content standards set forth at N.J.A.C. 7:27-25.3 are applicable to gasoline.

...

["Southern oxygen program control area" means the control area which includes the counties of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer and Salem.]

...

7:27-25.3 General provisions

(a)-(b) (No change.)

(c) Except as provided for at N.J.A.C. 7:27-25.9 [and 25.10], no refiner, importer, blender, distributor, wholesale purchaser-consumer, or retailer shall provide, store, offer for sale, sell, transport, import, or exchange in trade gasoline for use in New Jersey, unless:

1. The oxygen content of the gasoline equals or exceeds 2.7 percent[:

i. For the Northern oxygen program control area, from October 1 through and including the following April 30;

ii. For the Southern oxygen program control area,] from November 1 through and including the last day of the following February; and

2. (No change.)

(d)-(e) (No change.)

(f) Notwithstanding the provisions of (c) above, a refiner, importer, blender, or distributor may provide, store, offer for sale, sell, transport, import, or exchange in trade gasoline which has an oxygen content less than 2.7 percent, provided that:

1. The gasoline is destined for one of the following uses:

i. Provision, sale, or exchange in trade to a retailer or wholesale purchaser-consumer at a facility located outside the [northern oxygen program control area and the southern] oxygen program control area;

ii.-iv. (No change.)

2.-3. (No change.)

(g) Upon the request of any consumer, a retailer shall inform the consumer as to the [type of oxygenate(s)] **category of oxygenate, either alcohol or ether blends,** being dispensed from any of the gasoline dispensing devices at the facility.

7:27-25.4 Recordkeeping and compliance determinations

(a) Each refiner, importer, blender or distributor shall:

1. (No change.)

2. Certify to the distributor, retailer or wholesale purchaser-consumer to whom gasoline is delivered that the gasoline has been tested in accordance with this section; that, during the RVP control period, the gasoline has an RVP of 9.0 pounds per square inch or less; that, during any applicable oxygen content control period, the gasoline conforms with the oxygen content requirements of this

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subchapter; **the category of oxygenate, either alcohol or ether blends, being used in the gasoline;** and that the gasoline is in compliance with all applicable State and Federal regulations, by providing:

i.-ii. (No change.)

3. Maintain records on all gasoline leaving the refinery, import facility, blending facility, or distribution facility, which document the RVP and the oxygen content of gasoline, the [type] **category** and percent by volume of [each] **the** oxygenate**, either alcohol or ether blends,** [which comprises one percent or greater by volume of] **in** the gasoline, shipment quantity, shipment date, and other such information as the Department may prescribe. Documentation may include, but is not limited to, bills of lading, invoice delivery tickets, and loading tickets.

(b) Each retailer or wholesale purchaser-consumer shall maintain records on each delivery of gasoline, including RVP, oxygen content, [type] **category** and percent by volume of [each] **the** oxygenate**, either alcohol or ether blends,** [which comprises one percent or greater by volume of] **in** the gasoline, delivery quantity, date of delivery, and other such information as the Department may require. Documentation may include, but is not limited to, bills of lading and other transfer documents, invoice delivery tickets and loading tickets, and invoices and test reports certified pursuant to (a)2 above.

(c) (No change.)

(d) All testing for RVP required pursuant to the provisions of this subchapter shall be conducted using one of the following methods:

1. (No change.)

2. "Method 2—Herzog Semi-Automatic Method" promulgated at 40 CFR 80, Appendix E; [or]

3. "Method 3—Grabner Method" promulgated at 40 CFR 80, Appendix E; or

[3.]**4.** Any other equivalent test method approved in advance in writing by the Department and EPA.

(e)-(h) (No change.)

7:27-[25.10]**25.9** Variance for shortage of supply

(a)-(c) (No change.)

(d) Any application for a variance submitted to the Department pursuant to this subchapter shall include a service fee in accordance with N.J.A.C. 7:27-[25.12(c)]**25.11(c)** and shall be certified in accordance with N.J.A.C. 7:27-8.24.

(e)-(f) (No change.)

7:27-[25.11]**25.10** (No change in text.)

7:27-[25.12]**25.11** Service fees

(a)-(b) (No change.)

(c) Any person who applies for a variance pursuant to N.J.A.C. 7:27-25.9 [or 25.10] shall submit with the application a non-refundable service fee of $500.00. No application shall be deemed complete without the required fee.

(d) Any person to whom the Department has issued a variance pursuant to N.J.A.C. 7:27-25.9 [or 25.10] shall remit to the Department within 60 days after receipt of an invoice, a compliance inspection fee of $200.00. Such person is subject to a compliance inspection fee only if the Department conducts at the facility one or more compliance inspections pursuant to the variance during any year, or part thereof, that the variance is in effect. The Department shall not charge such person a compliance inspection fee more frequently than once per year.

7:27A-3.10 Civil Administrative Penalties for Violations of Rules Adopted Pursuant to the Act

(a)-(d) (No change.)

(e) The Department shall determine the amount of civil administrative penalty for offenses described in this section on the basis of the provision violated and the frequency of the violation. Footnotes 3, 4, and 8 set forth in this subsection and (f) below are intended solely to put violators on notice that in addition to any civil administrative penalty assessed the Department may also revoke the violator's operating certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an operating certificate or variance, but merely indicate the situations in which the Department is most likely to seek revocation. The number of the following subsections corresponds to the number of the corresponding subchapter in N.J.A.C. 7:27.

1.-24. (No change.)

25. The violations of N.J.A.C. 7:27-25, Control and Prohibition of Air Pollution by Vehicular Fuels, and the civil administrative penalty amounts for each violation, per source, are as set forth in the following table:

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Citation	Class	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
. . .					
[N.J.A.C. 7:27-25.9(l)	Records	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-25.9(m)2	Readily Available	$100	$200	$500	$1,500
N.J.A.C. 7:27-25.9(o)	Less than 15,000 gallon tank capacity.	$2,000	$4,000	$10,000	$30,000
	From 15,000 up to 50,000 gallon tank capacity.	$4,000	$8,000	$20,000	$50,000
	From 50,000 up to 500,000 gallon tank capacity.	$8,000	$16,000	$40,000	$50,000
	Greater than 500,000 gallon tank capacity.	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-25.9(p)1-3	Records Calculation/ Report	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-25.9(p)4	Records	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-25.9(p)5	Readily Available	$100	$200	$500	$1,500
N.J.A.C. 7:27-25.9(p)6	Submittal	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-25.9(p)7	Conditions of approval	$800	$1,600	$4,000	$12,000
N.J.A.C. 7:27-25.9(q)	Non-conforming gasoline & economic benefit	$800 + $.05 per gallon[1]	$1,600 + $.05 per gallon[1]	$4,000 + $0.5 per gallon[1]	$12,000 + $0.5 per gallon[1]]

N.J.A.C. 7:27-[25.10(i)]**25.9(i)** (No change.)
N.J.A.C. 7:27-[25.10(k)2]**25.9(k)2** (No change.)
N.J.A.C. 7:27-[25.10(l)1]**25.9(l)1** (No change.)
N.J.A.C. 7:27-[25.10(l)2]**25.9(l)2** (No change.)
N.J.A.C. 7:27-[25.10(l)3]**25.9(l)3** (No change.)
N.J.A.C. 7:27-[25.10(l)4]**25.9(l)4** (No change.)
N.J.A.C. 7:27-[25.10(l)5]**25.9(l)5** (No change.)

[[1]To determine the penalty due, multiply the per-gallon penalty amount by the number of additional gallons of the grade of gasoline with the highest oxygen content that were needed to be used, sold or otherwise exchanged in trade to have achieved a contemporaneous average of 2.7 percent oxygen.]
[2](No change.)

(a)

OFFICE OF AIR MANAGEMENT

Air Administrative Penalties and Requests for Adjudicatory Hearings

Proposed Amendments: N.J.A.C. 7:27A-3.2, 3.5 and 3.10

Authorized By: Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.
Authority: N.J.S.A. 13:1B-3, 13:1D-9, and 26:2C-1 et seq., in particular 26:2C-19.
DEPE Docket Number: 47-93-08/156.
Proposal Number: PRN 1993-504.

A **public hearing** concerning this proposal will be held on:
Tuesday, October 12, 1993 at 10:00 A.M.
New Jersey Department of Environmental Protection and Energy
Hearing Room, First Floor
401 East State Street
Trenton, New Jersey 08625

Submit written comments, identified by the Docket Number given above by October 27, 1993, to:
Janis Hoagland, Administrative Practice Officer
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

Copies of the proposed new rule will be available for inspection during normal office hours until October 27, 1993 at:
Atlantic County Health Department
201 South Shore Road
Northfield, NJ 08225
Middlesex County Air Pollution Control Program
County Annex Building
841 Georges Road
North Brunswick, NJ 08902
Warren County Health Department
319 West Washington Avenue
Washington, NJ 07882
New Jersey Department of Environmental Protection and Energy
Office of Energy
401 East State Street, Seventh Floor
Trenton, NJ 08625

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New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Northern Regional Office
1259 Route 46, Building 2
Parsippany, NJ 07054

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Southern Regional Office
20 East Clementon Road, Third Floor North
Gibbsboro, NJ 08026

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Metropolitan Regional Office
2 Babcock Place
West Orange, NJ 07052

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Central Regional Office
Horizon Center, Building 300
Route 130
Robbinsville, NJ 08691

The proposed amendments will become operative 60 days after adoption by the Commissioner (see N.J.S.A. 26:2C-8).

The agency proposal follows:

Summary

Highlights

The New Jersey Department of Environmental Protection and Energy (Department) is proposing amendments to N.J.A.C. 7:27A-3, Civil Administrative Penalties and Requests for Adjudicatory Hearings (Penalty Code). This proposal would amend the penalty amount and add penalties for violations of N.J.A.C. 7:27-8, Permit and Certificates, and add penalties for violations of proposed new rules N.J.A.C. 7:27-22, Operating Permits, published elsewhere in this issue of the New Jersey Register.

In a companion to this proposal, the Department is also proposing new rules and related amendments to N.J.A.C. 7:27-1, 8, 16, 18, 21 and 22. The purpose of the companion proposals is to establish a new State operating permit program for major stationary sources of air contaminants and to revise the preconstruction permit program. The Federal Clean Air Act, 42 U.S.C. 7401 et seq. (the CAA) as amended by the Clean Air Act Amendment of 1990, P.L. 101-549, November 15, 1990 (CAAA of 1990), requires that every state develop and submit to USEPA for approval programs for issuing operating permits to major stationary sources of air contaminants (see the companion proposed new rules N.J.A.C. 7:27-22). The state programs must be at least as stringent as the Federal requirements.

The New Jersey Air Pollution Control Act (1954), N.J.S.A. 26:2C-1 et seq., as amended by P.L. 1985, c.12 (the Act) empowers the Department to assess civil administrative penalties for each violation of the Act or of any rule promulgated or permit issued pursuant thereto. Effective January 5, 1990, the Department promulgated the Penalty Code to codify the procedures governing the assessment of civil administrative penalties for violations of the Act. The Act and the Penalty Code establish higher civil administrative penalties for repeat offenses.

The Department is proposing amendments to the Penalty Code to add a regulatory framework for enforcing the requirements of the proposed modifications to N.J.A.C. 7:27-8 and the proposed operating permit program in N.J.A.C. 7:27-22 and to add penalties for violations of previously adopted amendments to N.J.A.C. 7:27-8. The proposed amendments to the Penalty Code would amend: N.J.A.C. 7:27A-3.2, Definitions; 7:27A-3.5, Civil Administrative Penalty Determinations—General; and 7:27A-3.10, Civil Administrative Penalties for Violations of Rules Adopted Pursuant to the Act; including moving the Penalty Schedule to a newly designated, Civil Administrative Penalty Schedule ("CAP Schedule" or "Penalty Schedule") in the proposed N.J.A.C. 7:27A-3.10(l) and adding new penalties in N.J.A.C. 7:27A-3.10(m) for the following: violations of N.J.A.C. 7:27-8 and 7:27-22 as indicated by Continuous Monitoring Systems, for CMS not installed, out of service or out of control, and violations of CMS records and reporting requirements.

Pursuant to the Clean Air Act, the United States Environmental Protection Agency (EPA) established a National Ambient Air Quality Standard (NAAQS) for ozone, 42 U.S.C. 7409(a)(1). The Act requires any state in which the ambient air quality failed to achieve the NAAQS to submit a State implementation Plan (SIP) to EPA. 42 U.S.C. 7410. The SIP provides for the state to establish enforceable emission limitations and other control measures that would enable the state to achieve the standard.

New Jersey is subject to this requirement because it has not attained the NAAQS for ozone. Ozone is a respiratory irritant. A description of the problems associated with ozone is set forth in the Summary and Social Impact statement at 24 N.J.R. 1315, 1316, 1320 (April 6, 1992). EPA has designated 18 of the State's 21 counties as being in "severe" non-attainment for ozone, based upon ozone levels in those areas more than 50 percent above the NAAQS.

The CAAA of 1990 further directed states in which severe non-attainment areas were located to revise their SIPs to require sources of Volatile Organic Compounds (VOCs) to reduce emissions. In the presence of sunlight VOCs, oxides of nitrogen (NO_x) and other compounds in the ambient air react to form ozone.

The Department proposed amendments to N.J.A.C. 7:27-16, Control and Prohibition of Air Pollution by Volatile Organic Compounds, to reduce the formation of ground level ozone at 25 N.J.R. 3339(a) (August 2, 1993). The Department also proposed new rules governing control of air pollution from NO_x sources, N.J.A.C. 7:27-19 at 25 N.J.R. 631(a) (February 16, 1993).

Redesignation of Penalty "Classes"

The proposed recodified N.J.A.C. 7:27A-3.10(l) contains a Civil Administrative Penalty ("CAP" or Penalty) schedule for violations of N.J.A.C. 7:27, Air Pollution Control. This proposal would add several new provisions to and amend existing provisions in the Penalty Schedule for violations of N.J.A.C. 7:27-8 and the companion proposed new N.J.A.C. 7:27-22 as described below.

Major Source Operations:

The proposed amendments to N.J.A.C. 7:27A-3.10 would increase penalty amounts for permit violations for the approximately 350 facilities in the State that emit between 25 and 100 tons per year of VOCs and NO_x. The CAAA of 1990 defines such facilities in New Jersey as major stationary sources which are required to implement specified air pollution control technology. Prior to the CAAA of 1990, "major" sources were defined as emitting or having the potential to emit 100 tons per year of such air contaminants. The proposed amendment to the Penalty Schedule in N.J.A.C. 7:27-3.10(l) for violations of N.J.A.C. 7:27-8 and 7:27-22 are consistent with the proposed N.J.A.C. 7:27-16, and 7:27-19, which proposals were required by the CAAA of 1990. This proposed amendment to the Penalty Schedule would increase penalties for violations of rules governing VOCs and NO_x with the purpose of ensuring that those sources emitting such pollutants comply with the State requirements. Compliance with such requirements would reduce the formation of ground-level ozone and bring the State closer to achieving the ambient air standards for ozone, as required by the CAAA of 1990.

Source Operations with Low Emissions:

The proposed amendments to the Penalty Schedule would affect violations of N.J.A.C. 7:27-8 and 22. Certain penalties for violations of permits issued pursuant to N.J.A.C. 7:27-8 and 22 are classified in the Penalty Schedule according to the nature and amount of air contaminants emitted as well as according to certain federal designations. The existing penalty schedule contains four "categories" or "classes" of source operations. The proposed amendment would add a new "Class One" for source operations emitting the smallest amounts of pollutants (less than 0.5 pounds per hour). The other classes would be renumbered two through five. The penalty amounts for Class One would be from one-quarter (stack tests) to one-half (other permit violations) of the amounts for Class Two.

Hazardous Air Pollutants (HAP):

The proposed amendment to the Penalty Schedule would amend the highest penalty class of source operations proposed as Class Five to add those sources which emit the most severe hazardous air pollutants (HAP) regulated by the CAAA of 1990. The most severe HAPs are listed in HAP Table A and B of the companion proposal (N.J.A.C. 7:27-22).

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Notice Requirements under N.J.A.C. 7:27-8

The Department is also proposing new penalties in the Penalty Schedule for violations of proposed new N.J.A.C. 7:27-8.14(d), 8.15(d), 8.15(k), 8.16(c) and 8.17(b). In the companion proposal, the Department proposes new sections to N.J.A.C. 7:27-8 which would add N.J.A.C. 7:27-8.14(d) governing notification to the Department of administrative amendments, N.J.A.C. 7:27-8.15(d) requiring a permittee to provide notice to the Department of certain changes within seven days, N.J.A.C. 7:27-8.15(k) requiring a permittee to maintain a record of the seven day notice, N.J.A.C. 7:27-8.16(c) requiring Department approval of an application before an alteration may be made and N.J.A.C. 7:27-8.17(b) requiring submittal of a "seven day" notice and documentation of alteration for facility subject to Pollution Prevention Act. (See the companion proposal for a discussion of these proposed new requirements.)

The purpose of the proposed new penalties is to ensure compliance with these proposed new subsections of N.J.A.C. 7:27-8. The penalties for violations of proposed new N.J.A.C. 7:27-8.14(d), 8.15(d), 8.15(k), 8.16(c) and 8.17(b) are consistent with proposed penalties for violations of similar requirements in the proposed N.J.A.C. 7:27-22.

Additional requirements under N.J.A.C. 7:27-8

The Department is also proposing penalties in the Penalty Schedule for sections of N.J.A.C. 7:27-8 which have been previously adopted, but have not been assigned penalties. The proposed penalties are for violations of the following provisions: N.J.A.C. 7:27-8.4(c)1, 8.4(c)3, 8.4(c)4, 8.4(c)5, 8.4(c)6, 8.4(f), 8.4(g), 8.4(j), 8.9(a), 8.9(b), 8.9(c), and 8.9(d). The penalties for violations of these provisions are consistent with penalties in the Penalty Code for violations of similar requirements in N.J.A.C. 7:27.

Continuous Monitoring Systems

The Department had promulgated the Penalty Code based on the expectation that source operations would be inspected once a year for major sources and once every five years for minor sources. The advancement in technology has lead to the development of continuous monitoring systems (CMS) as enhanced tools to monitor emissions. Federal requirements first required the use of CMS on only certain categories of source operations. Subsequently, the Department has required that CMS be used, as a condition of approval for permits and certificates issued pursuant to N.J.A.C. 7:27-8 for certain source operations. The CAAA of 1990 will also require additional source operations to install CMS to monitor emissions, opacity or other process parameters. Therefore, the Department will be encouraging owners and operators to use their CMS as an additional means for detecting whether their source operation is complying with its air pollution control permit on a continuous rather than a periodic basis.

The proposed amendments to the Penalty Code provide for penalty amounts appropriate for violations determined by or involving the use of continuous monitoring systems. These proposed amendments include penalty provisions concerning the installation and operation of CMS. The amendments would also establish penalties for violations of permit conditions which are detected by CMS, such as emissions of air contaminants, opacity and process parameters such as oxygen, pH and temperature. The proposed amendments to N.J.A.C. 7:27-16 and the new N.J.A.C. 7:27-19 would require that certain sources install CMS to continuously measure emissions of VOCs and NO_x and process parameters set forth as conditions of their permits. The proposed amendments to N.J.A.C. 7:27A-3.10 would enforce the proposed requirements concerning CMS.

Joint and Several Liability for Penalties

The proposed new N.J.A.C. 7:27-22.3(f) provides that if the owner and operator of any facility, equipment, or source operation to which N.J.A.C. 7:27-8 or 22 applies are separate persons or if there is more than one owner or operator, each owner and each operator would be jointly and severally liable for any penalties for violation of N.J.A.C. 7:27-8 and 22. This is consistent with proposed new N.J.A.C. 7:27-19.3(a) at 25 N.J.R. 648 (February 16, 1993).

Public Involvement In the Rulemaking Process

The Department established a task force, with representatives from four operating resource recovery facilities in New Jersey, to assist the Department in the development of the proposed new provisions in N.J.A.C. 7:27A-3.10(m)1 concerning the continuous monitoring systems (CMS). The task force held eight meetings in 1992. The Department developed the CMS penalty proposal based on the Department's experience with CMS, suggestions made at the task force meetings, and discussions with the resource recovery facility operators, as well as with other industry representatives.

The specific provisions of the proposed amendments to the Penalty Code are discussed in more detail below.

N.J.A.C. 7:27A-3.2, Definitions

The Department is proposing to add new definitions to conform with the proposed amendments to N.J.A.C. 7:27-1, 16, 18 and 21, and proposed new rule N.J.A.C. 7:27-22. The terms include: "continuous emission monitor (CEM)," "continuous monitoring system (CMS)," "continuous opacity monitor (COM)," "continuous process monitor (CPM)," "hazardous air pollutant (HAP)" and "source operation." "CEM," "CMS," "COM" and "CPM" are discussed in the sections concerning continuous monitoring systems. These terms will be used in N.J.A.C. 7:27A-3.10 and paragraphs 8 and 22 of the Penalty Schedule in N.J.A.C. 7:27A-3.10(m) and (l). HAP is used in Class Five for violations of N.J.A.C. 7:27-8.3, 22.3, 22.14 and 22.15. "Source operations" is used throughout the proposed amendments to the Penalty Schedule.

N.J.A.C. 7:27A-3.5, Civil administrative penalty determination – general:

N.J.A.C. 7:27A-3.5 sets forth general provisions applicable to assessment of civil administrative penalties for violations of the Air Pollution Control Act, ("the Act") and the rule which the Department has promulgated under the authority of the Act. The Department is proposing to amend N.J.A.C. 7:27A-3.5(f) and add new subsections at N.J.A.C. 7:27A-3.5(g) and (h). The purpose of the proposed amendment to N.J.A.C. 7:27A-3.5(f) and the addition of the proposed new N.J.A.C. 7:27A-3.5(g) and (h) is to enhance the Department's flexibility in assessing civil administrative penalties for violations of N.J.A.C. 7:27-8.3 or the proposed N.J.A.C. 7:27-22.3 as indicated by a continuous monitoring system ("CMS").

Proposed new N.J.A.C. 7:27A-3.5(g) would establish a "cap" equal to the statutory maximum in the Act for penalties assessed in accordance with the proposed N.J.A.C. 7:27A-3.10(m)1, not to exceed $10,000 for the first offense, $25,000 for the second offense and $50,000 for the third and each subsequent offense for violation of N.J.A.C. 7:27-8.3(e) and 22.3(c) as indicated by a CMS. The proposed new N.J.A.C. 7:27A-3.5(g) also establishes discretionary authority in the Department to treat an offense as a first offense at the beginning of each calendar quarter, for the purpose of reducing this "cap."

Proposed new N.J.A.C. 7:27A-3.5(h) establishes the discretionary authority for the Department to treat an offense as a first offense, if the violator did not commit the same offense within the previous 12 months in assessing civil administrative penalties for violations of N.J.A.C. 7:27-8.3(e) and 22.3(d) or (e), when a continuous monitoring system operates out of control or is out of service.

N.J.A.C. 7:27A-3.10, Civil administrative penalties for violations of rules adopted pursuant to the Act:

A. The Department is proposing the following amendments and new additions to N.J.A.C. 7:27A-3.10 at subsections (a), (d), (e), (f), (g), (i) and (j).

1. The purpose of the amendment to N.J.A.C. 7:27A-3.10(a) and (d) is to clarify the use of subsections (e), (f), (l) and (m) discussed below.

2. Proposed new N.J.A.C. 7:27A-3.10(e) and (f) correspond with proposed N.J.A.C. 7:27A-3.5(g) and (h) as discussed above in the summary for N.J.A.C. 7:27A-3.5.

3. The purpose of proposed new N.J.A.C. 7:27A-3.10(g) is to establish discretionary authority for the Department to assess the highest civil administrative penalty in instances when the civil administrative penalty schedule may provide for more than one method of penalty assessment for a particular violation in order to provide a sufficient deterrent effect.

4. The purpose of proposed new N.J.A.C. 7:27A-3.10(i) is to clarify that the Department has discretionary authority to adjust the amount of any penalty determined under this section prior to the assessment of a civil administrative penalty. Adjustments would be made pursuant to the factors listed in the previously proposed amendments to N.J.A.C. 7:27A-3.5, which is discussed in the new RACT requirement for control of NO_x, N.J.A.C. 7:27-19 at 25 N.J.R. 631(a) (February 16, 1993).

5. Proposed new N.J.A.C. 7:27A-3.10(j) would establish procedures for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-22. Further explanation is provided in the discussion of N.J.A.C. 7:27A-3.10(l) under section B of this summary below.

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B. The proposed provision at N.J.A.C. 7:27A-3.10(l) sets forth the civil administrative penalties for violations of N.J.A.C. 7:27 as previously established in N.J.A.C. 7:27A-3.10(e) with some amendments and new provisions.

Penalties for Violations of N.J.A.C. 7:27-8 Permit and Certificates

Paragraph 8 in the Civil Administrative Penalty ("CAP" or "Penalty") Schedule in N.J.A.C. 7:27A-3.10(l) establishes civil administrative penalties for violations of the proposed amendments to N.J.A.C. 7:27-8 as well as for violations of the previously adopted amendments to N.J.A.C. 7:27-8 (effective March 31, 1991). The penalties for violations of the proposed amendments to N.J.A.C. 7:27-8 correspond to the penalties for the violations of the proposed new N.J.A.C. 7:27-22.

The new format in the Penalty Schedule adds a "Rule Summary" for each subsection of N.J.A.C. 7:27-8 and listed in the Schedule. The Rule Summary is provided for informational purposes only and shall have no legal effect. The proposed amendments would add penalties for violations of the following provisions of N.J.A.C. 7:27-8.

1. The proposed amendments to N.J.A.C. 7:27-8.3(a), (b) and (e) add a class of source operations (Class One) for small individual source operations that emit less than 0.5 pound per hour. The purpose of this amendment is to provide relief for small emission operations which are less likely to have a serious harmful effect on air quality. This class would not include source operations with violations measured and recorded by a continuous monitoring system (CMS) or source operations emitting severe hazardous air pollutants (HAP Table A and B in Class Five). (See N.J.A.C. 7:27A-3.10(m) below for an explanation under CMS and subsection 3 of this summary below and companion proposed new N.J.A.C. 7:27-22.)

2. The proposed amendments to N.J.A.C. 7:27-8.3(a), (b) and (e) increase penalties for violations of requirements by certain source operations emitting volatile organic compounds (VOCs) and oxides of nitrogen (NO_x). These requirements include constructing without a permit, operating without a certificate, exceeding emission limits and violating conditions of a permit or certificate.

The Federal CAAA of 1990 mandates that states, such as New Jersey, with severe non-attainment of the national ambient air quality standards for ground-level ozone, consider those sources with the potential to emit 25 tons per year of VOC and NO_X as "major" stationary sources. Such major sources are required to implement reasonable available control technology. The United States Environmental Protection Agency defined RACT in 44 Fed. Reg. 53762 (September 17, 1979). There are approximately 350 facilities statewide that may emit VOCs and NO_X in excess of 25 tons per year.

The Department proposed new RACT requirement for control of NO_x, N.J.A.C. 7:27-19, at 25 N.J.R. 631(a) (February 16, 1993) and proposed amendments and new rules for VOC, N.J.A.C. 7:27-16, at 25 N.J.R. 3339(a) (August 2, 1993). Major source operations would be regulated by the Department under the proposed amendments to N.J.A.C. 7:27-16, and proposed new rules N.J.A.C. 7:27-19 and 22. (See also the discussion in the summary above in the "highlights" and "major source operations" sections.)

3. The proposed amendments to N.J.A.C. 7:27-8.3(a), (b) and (e) add a new higher penalty level for source operations emitting the most severe hazardous air pollutants (HAPs) regulated by the CAAA of 1990. Those source operations emitting the most severe HAPs are designated as "Class Five" and would be assessed the highest penalties. The penalty amounts for first offenses would range between $2,000 and $10,000 depending upon the nature and extent of the violations.

4. The proposed amendment to N.J.A.C. 7:27-8.3(e) adds a section for violations concerning Continuous Monitoring Systems which is discussed in section C of the summary below.

5. As part of a companion proposal, proposed amendments to N.J.A.C. 7:27-8 would correspond with the proposed new N.J.A.C. 7:27-22. These new subsections include: N.J.A.C. 7:27-8.14(d), Administrative amendment notification; N.J.A.C. 7:27-8.15(d), Seven-day-notice change; N.J.A.C. 7:27-8.15(k), Maintain record of seven-day-notice; N.J.A.C. 7:27-8.16(c), Alteration without approval; and N.J.A.C. 7:27-8.17(b), Summit seven-day-notice and documentation of alteration for facilities subject to Pollution Prevention Act. The proposed penalties for these new subsections would be based on the severity of the offense, and would be $200.00, $300.00, $100.00, $800.00, or $300.00, respectively, for a first offense.

6. The Department is also proposing amendments to the Penalty Schedule which would add penalties for violations of the following provisions of N.J.A.C. 7:27-8 which were adopted (effective March 31, 1991):

- N.J.A.C. 7:27-8.4(c)1 may require an applicant for an operating certificate or renewal to submit source specific testing protocol;
- N.J.A.C. 7:27-8.4(c)3 may require an applicant for an operating certificate or renewal to conduct source specific testing;
- N.J.A.C. 7:27-8.4(c)4 requires an applicant to provide notice of source specific testing;
- N.J.A.C. 7:27-8.4(c)5 requires an applicant to submit test reports;
- N.J.A.C. 7:27-8.4(c)6 requires an applicant to certify test reports;
- N.J.A.C. 7:27-8.4(f) may require an applicant to conduct air quality impact analysis;
- N.J.A.C. 7:27-8.4(g) requires a permittee to submit an application for renewal;
- N.J.A.C. 7:27-8.4(j) may require a permittee to conduct air quality impact analysis;
- N.J.A.C. 7:27-8.9(a) requires a permittee to submit records;
- N.J.A.C. 7:27-8.9(b) requires a permittee to submit reports;
- N.J.A.C. 7:27-8.9(c) requires a permittee to certify reports; and
- N.J.A.C. 7:27-8.9(d) requires a permittee to submit emission report.

The proposed penalty amounts for violations of N.J.A.C. 7:27-8 are consistent with penalties in N.J.A.C. 7:27A-3 for violations of other comparable rules in N.J.A.C. 7:27. For example, the proposed penalty amounts for violations of source testing and notice, submit and certify test report, air quality impact analysis, records and reporting requirements correspond to penalties for similar violations under N.J.A.C. 7:27-16. Penalties for applications for renewal correspond with penalties under N.J.A.C. 7:27-8.

The table below outlines provisions for subchapter 8 for which a penalty for violation is proposed as follows: (1) for modifications to existing penalties cited under N.J.A.C. 7:27-8.3 (discussed in the summary sections B1 through B3 above); (2) for amendments previously adopted effective March 31, 1991; (3) for amendments to N.J.A.C. 7:27-8 which correspond to the proposed N.J.A.C. 7:27-22.

Provisions of subchapter 8 for which a penalty for violation is proposed:	Provision of existing rules with corresponding penalty for comparable violation:
N.J.A.C. 7:27-8.3(a), (b) and (e)[1]	*(see B1-3 above)
N.J.A.C. 7:27-8.3(e)[1] (Emission detected by CMS)	*(see C below)
N.J.A.C. 7:27-8.4(c)1[2]	*
N.J.A.C. 7:27-8.4(c)3[2]	**N.J.A.C. 7:27-16.9(d) [16.22(d)]
N.J.A.C. 7:27-8.4(c)4[2]	**N.J.A.C. 7:27-16.9(c) [16.22(c)]
N.J.A.C. 7:27-8.4(c)5[2]	**N.J.A.C. 7:27-16.6(i)2 [16.18(j)2]
N.J.A.C. 7:27-8.4(c)6[2]	**N.J.A.C. 7:27-16.4(m) [16.6(m)]
N.J.A.C. 7:27-8.4(f)[2]	**N.J.A.C. 7:27-16.9 [16.22(d)]
N.J.A.C. 7:27-8.4(g)[2]	N.J.A.C. 7:27-8.3(a)
N.J.A.C. 7:27-8.4(j)[2]	**N.J.A.C. 7:27-16.9(d) [16.22(d)]
N.J.A.C. 7:27-8.9(a)[2]	N.J.A.C. 7:27-16.6(m)
N.J.A.C. 7:27-8.9(b)[2]	**N.J.A.C. 7:27-16.6(i)2 [16.18(j)2]
N.J.A.C. 7:27-8.9(c)[2]	**N.J.A.C. 7:27-16.4(m) [16.6(m)]
N.J.A.C. 7:27-8.9(d)[2]	**N.J.A.C. 7:27-16.6(i)2 [16.18(j)2]
N.J.A.C. 7:27-8.14(d)[3]	N.J.A.C. 7:27-8.3(a)
N.J.A.C. 7:27-8.15(d)[3]	**N.J.A.C. 7:27-16.4(m) [16.6(m)]
N.J.A.C. 7:27-8.15(k)[3]	N.J.A.C. 7:27-8.3(d)
N.J.A.C. 7:27-8.16(c)[3]	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-8.17(b)[3]	**N.J.A.C. 7:27-16.4(m) [16.6(m)]

*See discussion in this summary

**See 25 N.J.R. 3339(a) (August 2, 1993) for proposed amendments to and recodification of N.J.A.C. 7:27-16. Material in brackets [ ] shows the proposed new citation.

[1]Existing penalties for which modifications have been proposed.

[2]Provisions of subchapter 8 as amended on March 31, 1991 for which civil administrative penalties had not previously been established.

[3]Proposed amendments to N.J.A.C. 7:27-8 to correspond to the proposed N.J.A.C. 7:27-22.

N.J.A.C. 7:27-8.4(c)1

The Department is proposing a civil administrative penalty for owners who fail to submit a source specific testing protocol as required pursuant to N.J.A.C. 7:27-8.4(c)1. An operator must obtain DEPE approval of a source specific testing protocol before it may conduct a stack test. The

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requirement to stack test is an important condition in a Certificate to Operate since the test determines whether a source operation is complying with emission limits. Failure to submit a protocol would delay stack testing. By proposing penalties for violating the requirement to submit a protocol, the Department seeks to encourage timely submissions of protocols. The proposed penalty for a first offense is $1,000. The proposed penalty amount for failure to submit the source specific testing protocol is one-half of the penalty for failure to conduct stack emission testing. (See also discussion in Summary of N.J.A.C. 7:27-22.18 below.)

Penalties for Violations of N.J.A.C. 7:27-22 Operating Permits

Paragraph 22 in the Civil Administrative Penalty ("CAP" Schedule or "Penalty") Schedule in N.J.A.C. 7:27A-3.10(l) would establish civil administrative penalties for violations of the proposed N.J.A.C. 7:27-22. In establishing the proposed penalty amounts, the Department has applied the following criteria:

1. The potential or actual health and environmental impacts of the violation, including the characteristics and quantity of the air contaminants regulated, the magnitude of the areas affected and the air quality of the area affected;

2. The deterrent value of the penalty and whether the proposed penalty amounts are appropriate to ensure compliance with N.J.A.C. 7:27-8 and 22; and

3. Consistency with penalties in N.J.A.C. 7:27A-3 for violations of other comparable rules in N.J.A.C. 7:27. For example, the penalties for violations of emission limits established under N.J.A.C. 7:27-22 correspond to penalties for violations of emission limits established under N.J.A.C. 7:27-8 for source operations in similar source categories. Penalties for violations of recordkeeping and reporting requirements in subchapters 8 and 22 correspond to existing penalty amounts in N.J.A.C. 7:27A for similar violations of N.J.A.C. 7:27. Except as indicated, the following table below shows the provisions of N.J.A.C. 7:27-22 for which a penalty for violation is proposed, and the rules which have comparable requirements in N.J.A.C. 7:27 and comparable penalties in N.J.A.C. 7:27A-3.

Provisions of subchapter 22 for which a penalty for violation is proposed:	Provision of existing rules with corresponding penalty for comparable violation:
N.J.A.C. 7:27-22.3(a)	*N.J.A.C. 7:27-8.3(b)
N.J.A.C. 7:27-22.3(b)	N.J.A.C. 7:27-8.3(b)
N.J.A.C. 7:27-22.3(c)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.3(c) (Emissions detected by CMS)	*
N.J.A.C. 7:27-22.3(d)	N.J.A.C. 7:27-8.3(e)2
N.J.A.C. 7:27-22.3(e)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.3(q)	**N.J.A.C. 7:27-16.4(m) [16.6(m)]
N.J.A.C. 7:27-22.5(b)	N.J.A.C. 7:27-8.3(a) and (b)
N.J.A.C. 7:27-22.8(a)	N.J.A.C. 7:27A-3.6(c)2
N.J.A.C. 7:27-22.8(d)	N.J.A.C. 7:27A-3.6(c)2
N.J.A.C. 7:27-22.8(e)	N.J.A.C. 7:27A-3.6(c)2
N.J.A.C. 7:27-22.9(a)	*
N.J.A.C. 7:27-22.9(b)	*
N.J.A.C. 7:27-22.14(e)	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-22.14(f)	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-22.15(b)1	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.15(b)3	**N.J.A.C. 7:27-16.4(n) [16.6(n)]
N.J.A.C. 7:27-22.18(b)	*
N.J.A.C. 7:27-22.18(d)	*
N.J.A.C. 7:27-22.18(e)1	**N.J.A.C. 7:27-16.9(c) [16.22(c)]
N.J.A.C. 7:27-22.18(e)2	**N.J.A.C. 7:27-16.9(d) [16.22(d)]
N.J.A.C. 7:27-22.18(e)3	**N.J.A.C. 7:27-16.6(i)2 [16.18(j)2]
N.J.A.C. 7:27-22.18(f)	**N.J.A.C. 7:27-16.9(d) [16.22(d)]
N.J.A.C. 7:27-22.18(g)3	**N.J.A.C. 7:27-16.9(c) [16.22(c)]
N.J.A.C. 7:27-22.18(g)4	**N.J.A.C. 7:27-16.6(l) [16.18(l)]
N.J.A.C. 7:27-22.18(g)5	**N.J.A.C. 7:27-16.6(i)2 [16.18(j)2]
N.J.A.C. 7:27-22.18(h)	**N.J.A.C. 7:27-16.4(m) [16.6(m)]
N.J.A.C. 7:27-22.19(a)	N.J.A.C. 7:27-16.6(m)
N.J.A.C. 7:27-22.19(c)	**N.J.A.C. 7:27-16.6(i)2 [16.18(j)2]
N.J.A.C. 7:27-22.19(f)	*
N.J.A.C. 7:27-22.19(g)2	**N.J.A.C. 7:27-16.4(m) [16.16(m)]
N.J.A.C. 7:27-22.19(h)	N.J.A.C. 7:27-16.6(m)
N.J.A.C. 7:27-22.19(j)	**N.J.A.C. 7:27-16.9(a) [16.22(a)]
N.J.A.C. 7:27-22.20(c)	N.J.A.C. 7:27-8.3(a)
N.J.A.C. 7:27-22.21(c)	**N.J.A.C. 7:27-16.6(i)1 [16.18(j)]
N.J.A.C. 7:27-22.22(d)	**N.J.A.C. 7:27-16.4(m) [16.6(m)]
N.J.A.C. 7:27-22.22(l)	N.J.A.C. 7:27-8.3(d)
N.J.A.C. 7:27-22.23(b)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.23(d)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.24(a)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.25(b)	**N.J.A.C. 7:27-16.9(c) [16.22(c)]
N.J.A.C. 7:27-22.26(d)	N.J.A.C. 7:27-8.3(b)
N.J.A.C. 7:27-22.26(k)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.26(p)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-22.27(c)	**N.J.A.C. 7:27-16.6(i)1 [16.18(j)1]
N.J.A.C. 7:27-22.28(i)	**N.J.A.C. 7:27-16.6(i)1 [16.18(j)1]
N.J.A.C. 7:27-22.30(b)	N.J.A.C. 7:27-8.3(e)1

*See discussion below.

**See 25 N.J.R. 3339(a) (August 2, 1993) for proposed amendments to and recodification of N.J.A.C. 7:27-16. Material in brackets [ ] shows the proposed new citation.

N.J.A.C. 7:27-22.3(a)

The penalty amount for a violation of N.J.A.C. 7:27-22.3(a), failure to obtain an operating permit, is comparable to the penalty amount for a violation of N.J.A.C. 7:27-8.3(b), failure to obtain a Certificate to Operate. As discussed above, proposed new rules N.J.A.C. 7:27-22 would establish a new facility-wide operating permit program for major sources of air pollution. Under proposed N.J.A.C. 7:27-22.3(a), a facility-wide permit would include all source operations at the facility regardless of whether those source operations were subject to the preconstruction permits and certificates to operate requirements of N.J.A.C. 7:27-8.3. This contrasts with N.J.A.C. 7:27-8.3, which requires an individual source operation that meets the applicability requirements of the subchapter to obtain a preconstruction permit and certificate to operate prior to installation and operation.

The penalty amount for a violation of N.J.A.C. 7:27-22.3(a) would be determined by adding together penalties attributable for each source operation as determined by the Penalty Schedule. The penalties for first offenses range from $100.00 for the smallest emission source to $2,000 for the most environmentally significant source operation. The total penalty for failure to obtain a facility-wide operating permit pursuant to N.J.A.C. 7:27-22.3 would be the sum of the penalties for each source operation, up to the statutory maximum ($10,000 for the first offense, $25,000 for the second offense and $50,000 for the third and each subsequent offense).

The proposed new penalties for violations of N.J.A.C. 7:27-22.3, Operating a source operation without a permit or failing to comply with a permit, for small sources, major stationary sources, and HAP sources are discussed in the summary of proposed amendments to Subchapter 8, N.J.A.C. 7:27A-3.10, located in A1, 2, and 3 above.

N.J.A.C. 7:27-22.3(c) and (e)

The penalties for emissions and other permit violations of N.J.A.C. 7:27-22.3(c) and (e), as determined by continuous monitoring systems, are discussed below in the explanation of the proposed N.J.A.C. 7:27A-3.10(m).

N.J.A.C. 7:27-22.9(a) and (b)

The Department is proposing civil administrative penalties for the failure to submit the proposed compliance plan for an Operating Permit or a renewal or modification to the permit, pursuant to N.J.A.C. 7:27-22.9. The proposed penalty for a first offense is $1,000. The Department believes the amount of penalties proposed above will emphasize the importance of the proposed compliance plan to the Operating Permit and thus, provide an adequate deterrence to noncompliance with N.J.A.C. 7:27-22.9(a) and (b). The required contents of a proposed compliance plan is set forth in N.J.A.C. 7:27-22.9(c). The amount of the proposed penalty for an incomplete submittal is one-half the amount of the proposed penalty for the failure to submit the proposed compliance plan at all.

N.J.A.C. 7:27-22.18(b) and (d)

The Department is proposing a civil administrative penalty for failure to submit a source emission testing and monitoring protocol as required pursuant to N.J.A.C. 7:27-22.18(b). The proposed penalty for a first offense is $1,000. Submittal of the source emission testing protocol in accordance with N.J.A.C. 7:27-22.18(b) is imperative to assure accurate source emission testing as required in N.J.A.C. 7:27-22.18(e)2.

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The proposed penalty for failure to submit the source emission testing protocol is one-half the penalty for failure to conduct the source emission testing. If the failure to submit the source emission testing protocol results in the failure to conduct the source emission testing in accordance with N.J.A.C. 7:27-22.18(e)2, the Department shall assess the appropriate penalties for violations of both N.J.A.C. 7:27-22.18(b) and 22.18(e)2. The Department is proposing a civil administrative penalty for the failure to resubmit a source emission testing and monitoring protocol in accordance with N.J.A.C. 7:27-22.18(d). The amount of the proposed penalty for the failure to resubmit a protocol is one-half the amount of the proposed penalty for the failure to submit a protocol at all. (See also discussion in Summary of N.J.A.C. 7:27-8.4(c)1 above.)

N.J.A.C. 7:27-22.19(f)

The Department is proposing a civil administrative penalty for the failure to submit a periodic compliance certification for an Operating Permit in accordance with N.J.A.C. 7:27-22.19(f). The proposed penalty for a first offense is $1,000. The Department believes the amount of the penalty proposed above will emphasize to the regulated community the importance of the periodic compliance certification as part of the Operating Permit and would deter noncompliance with N.J.A.C. 7:27-22.19(f).

C. N.J.A.C. 7:27A-3.10(m), Continuous Monitoring Systems (CMS):

1. CMS Reported Violations

This proposed new subsection would establish penalties for violations concerning three types of continuous monitoring systems (CMS) regulated under N.J.A.C. 7:27-8 and proposed new N.J.A.C. 7:27-22: continuous emission monitors (CEMs) that continuously monitor emissions of air contaminants; continuous opacity monitors (COMs) that continuously monitor opacity (shade or appearance of the flue gas); and continuous process monitors (CPMs) for other process parameters (such as temperature, flow rate, pH and oxygen). The proposed penalties are based on the nature and quantity of emissions, type of source operation, degree of deviation from a standard, the duration of offense, and the averaging time or length of the standard.

The Department has previously relied on stack emission tests, inspections and self-reporting to determine compliance with a source operation's allowable emission limit or other parameters or conditions set forth in an operator's permit. With advancements in emission monitoring technology such as continuous monitoring systems, the Department began to rely on these enhanced measurement tools to detect violations of emissions and process parameters. New Jersey has approximately 485 sources with continuous emission monitors. Due to the use of CMS and the anticipated increase in such use as driven by the requirements of the CAAA of 1990, the Department is proposing these amendments to N.J.A.C. 7:27A-3.10 to set forth penalty amounts for violations of N.J.A.C. 7:27-8 and 22 detected by CMS.

The Federal requirements for continuous monitoring systems were first established under the Federal Standards of Performance for New Stationary Sources (also known as new source performance standards or NSPS) as set forth in 40 C.F.R. Part 60 for individual source categories. The first CMS in New Jersey were required for refineries in 1980. Subsequently, the Department aslo requires that CMS be installed for other source operations. Such requirements have been included as condition(s) of approval for permits issued pursuant to N.J.A.C. 7:27-8.

Related Department Proposed New Rules and Amendments:

The Department has proposed other new rules and related amendments which would require additional monitoring, reporting, record keeping, or testing requirements on major stationary source operations. These proposals, including proposed amendments to N.J.A.C. 7:27-16, Control and Prohibition of Air Pollution by Volatile Organic Compounds at 25 N.J.R. 3339(a) (August 2, 1993); new proposed rules N.J.A.C. 7:27-19, Control and Prohibition of Air Pollution from Oxides of Nitrogen at 25 N.J.R. 631(a) (February 16, 1993); and N.J.A.C. 7:27-21, Emission Statements (published elsewhere in this issue of the New Jersey Jersey Register), are made in response to the Clean Air Act Amendments of 1990 (CAAA of 1990). The Department estimates that these previously proposed new rules and related proposed amendments and companion proposed new rules N.J.A.C. 7:27-22 would require that additional facilities install CMS. Such facilities would potentially be affected by the proposed new penalty rules in N.J.A.C. 7:27-3.10(m).

Penalty Amounts for CMS Detected Offenses:

Since CMS operate on a continuous basis, they would detect more violations of emission allowable limits or other parameters than would stack emission tests which are performed annually or once every five years. Therefore, under proposed new N.J.A.C. 7:27A-3.10(m)1, the Department would assess more civil administrative penalties for those more frequently reported violations. However, in most cases the individual penalty amounts determined by proposed new N.J.A.C. 7:27A-3.10(m)1 would be lower than penalties determined by existing N.J.A.C. 7:27A-3 for violations of N.J.A.C. 7:27-8 not detected by CMS.

Many source operations are required to install continuous monitoring systems (CMS) as conditions of approval for preconstruction permits and operating certificates issued pursuant to N.J.A.C. 7:27-8 to continuously monitor emissions or other permit parameters. A CMS detected emissions, opacity or other process parameter offense is treated as a violation of a condition of approval for a preconstruction permit and operating certificate under N.J.A.C. 7:27-8.3(e). The penalty amounts for first offenses in the existing rule range between $800.00 and $3,000 dependent upon such factors as the quantity and nature of air contaminant being emitted and the type of source operation.

Under proposed new N.J.A.C. 7:27A-3.10(m)1, the penalty amount for a CMS detected violation regulated under N.J.A.C. 7:27-8 or proposed new N.J.A.C. 7:27-22 will be based upon the nature and quantity of air contaminant and the type of source operation, as well as such additional factors as the degree of deviation from a standard and the duration of the offense. Pursuant to N.J.A.C. 7:27A-3.5(g) and 3.10(e), the Department may treat an offense as a first offense for penalty calculation purposes only, at the beginning of each calendar quarter, even though the owner or operator had a previous offense in the prior calendar quarter.

To determine the penalty amount for a violation detected by CMS, multiply the base penalty from Tabel 2A (major source) or Table 2B (minor source) by the multiplier (Table 3). The level of offense is determined in Table 1. The procedure for using these tables is outlined below and illustrated by an example.

- Table 1 establishes the level of offense based on the degree of deviation from the standard for an allowable emission or concentration rate or other parameters such as oxygen, pH or temperature.
- Table 2A shows the base penalty for major sources of air pollution based on the level of violation obtained from Table 1.
- Table 2B shows the base penalty for minor sources of air pollution based on the level of violation obtained from Table 1.
- Table 3 shows the multiplier which would be applied to the base penalty obtained from either Table 2A or 2B. Each multiplier in Table 3 corresponds to the duration of the offense or the length of the averaging time set forth in a preconstruction permit and operating certificate issued pursuant to N.J.A.C. 7:27-8 or in an operating permit issued pursuant to N.J.A.C. 7:27-22.

Example of Penalty Calculation for Violation Detected by CMS:

An example of how the proposed CMS penalty amounts would be determined is provided here and in the proposed new rule for illustration only. The example applies to the above-described four tables in N.J.A.C. 7:27A-3.10(m)1 and shall have no legal effect.

Example:

A major source operation emitted oxides of nitrogen (NO_x) at a concentration rate of 350 parts per million during a one hour time period while the allowable emission limit in the Operating Permit was 300 parts per million with a one hour averaging time.

Penalty Calculation:

Using Table 1, determine the level of offense for the air contaminant (NO_x). Because the violator emitted NO_x at a concentration less than 25 percent above the allowable emission limit, the Level of Offense is Level I. The source operation is considered major because it emits NO_x in excess of 5.7 pounds per hour: Using Table 2A for a major source operation, determined the based penalty that corresponds to Level I. For a major source operation the base penalty for a Level I offense is $200.00. Using Table 3, determine the multiplier corresponding to a 1 hour averaging time. Multiply $200.00 by 2, the multiplier from Table 3. The penalty for the offense is $400.00.

2. CMS Not Installed, Out of Service or Out of Control

This paragraph establishes penalties for permit violations by source operations that fail to install continuous monitoring systems (CMS) as required by their permit or that fail to maintain or operate the CMS in accordance with their permit, regulated under N.J.A.C. 7:27-8.3(e) or the proposed N.J.A.C. 7:27-22.3(d) or (e). The purpose of proposed

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N.J.A.C. 7:27A-3.10(m)2 is to reduce penalty amounts to account for possible delays in the installation of CMS and possible failures or malfunctions that may occur on those systems.

Certain source operations are required to install, maintain and operate a CMS as conditions of approval for preconstruction permits and operating certificates issued pursuant to N.J.A.C. 7:27-8. An offense by a source operation of one of these permit requirements would be treated as a violation of a condition of approval under N.J.A.C. 7:27-8.3(e). The penalty amounts for first offenses as determined by the existing N.J.A.C. 7:27A-3, are between $800.00 and $3,000 dependent upon such factors as the quantity and nature of the air contaminants being emitted and the type of source operations.

The Department has proposed a two-tiered penalty in this section for major and minor source operations. The proposed penalties will range between $100.00 and $500.00 for a first offense, dependent upon the size of the source operation. In addition, proposed N.J.A.C. 7:27A-3.5(h) and 3.10(f) also establishes a "clean slate" provision. If an owner or operator has not committed the same offense in the year preceding the date of the pending offense, the penalty for a new offense is calculated at the first offense level. The provision for a "clean slate" after one year applies only to violations of N.J.A.C. 7:27-8.3(e) and 22.3(d) and (e) when the CMS operates out of control or is out of service.

3. CMS Records and Reporting

The proposed amendment would establish penalties for permit violations by source operations for CMS records and reporting requirements regulated pursuant to N.J.A.C. 7:27-8.3(e) or proposed N.J.A.C. 7:27-22.3(e). The purpose of the amendment would establish consistency with penalties from other sections of the penalty code involving source operations not using CMS for records and reporting offenses. The penalty amounts for CMS records and reporting would be in most cases be lower than for permit violations determined by existing N.J.A.C. 7:27A-3.

CMS recordkeeping and reporting requirements are included as conditions of approval for preconstruction permits and operating certificates issued pursuant to N.J.A.C. 7:27-8. Therefore, a CMS record or reporting offense is a violation of such conditions. Under the existing N.J.A.C. 7:27A-3, the penalty amounts for first offense violations are between $800.00 and $3,000 dependent upon such factors as the quantity and nature of the air contaminant being emitted and the type of source operation. However, under this proposal, the penalty amounts would be either $300.00 or $500.00 per monitor, for first offenses of CMS reporting or records requirements under N.J.A.C. 7:27-8 or proposed new N.J.A.C. 7:27-22, with higher civil administrative penalties for repeat offenses. This proposed amendment for penalties is comparable for violations with other sections of the penalty code for recordkeeping and reporting offenses involving sources not using CMS.

Social Impact

The proposed amendments to N.J.A.C. 7:27A-3.2, 3.5 and 3.10 will have a positive social impact by encouraging compliance and discouraging noncompliance with the State's air pollution control laws and regulations. Therefore, the general public will benefit from the improved air quality which is expected to result from better compliance by facilities with their emission standards and other permit requirements.

Economic Impact

In general, the proposed penalty amendments will not impose additional monitoring, reporting, recordkeeping, and testing requirements on businesses. As discussed in the Summary, the Department is proposing new rules and related amendments to N.J.A.C. 7:27 in response to the CAAA of 1990. These new rules and related amendments will impose additional monitoring, reporting, recordkeeping, and testing requirements on source operations. The economic cost associated with these additional requirements are discussed in the respective proposal documents of the new rules and related amendments, especially N.J.A.C. 7:27-16 and N.J.A.C. 7:27-19 (Control and Prohibition of Air Pollution by Volatile Organic Compounds and Control and Prohibition of Air Pollution from oxides of Nitrogen). The proposed amendments to N.J.A.C. 7:27A-3.10 will have an adverse economic impact only upon those persons who violate these rules.

Although some of the proposed penalties are equivalent to or slightly less than those currently being assessed, some of the penalties for violations by sources emitting VOC and NO_x are potentially higher because of the redesignation of a major source from 100 tons per year or greater to 25 tons per year or greater. The proposed penalty amendments will provide a sufficient deterrent to discourage noncompliance with emission standards and other permit requirements and ensure that the penalties exceed any savings achieved by noncompliance and remove any competitive advantages gained by noncompliance.

Environmental Impact

The proposed amendments to the Penalty Code would have a positive environmental impact by serving as a strong deterrent to prevent persons from violating emission standards and other permit requirements. The development in technology of continuous monitoring systems as enhanced enforcement tools to detect the frequency of excess emissions and other permit parameters coupled with the proposed penalty amendments, provide the regulated community with a strong incentive to conduct their activities in accordance with emission standards and permit requirements. The potential reduction of air pollution will protect the environment and the health, welfare and the property of our citizens.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has made the following determinations as they would apply to small businesses. As discussed in this Summary, the Department is proposing new rules and related amendments in the companion proposals in response to the CAAA of 1990. These amendments and new rules will impose additional monitoring, reporting, recordkeeping, and testing requirements on those source operations that meet the applicability requirements. The companion proposed new rules and related amendments apply to certain source operations depending on the nature and extent of emissions. Small businesses are less likely to operate the larger sources which are subject to the provisions in the companion proposal. Thus small businesses are less likely to be affected by penalty rules which would enforce the companion proposal.

The proposed amendments establish a lower penalty for source operations which have lower allowable emission limits. The majority of sources operated by small businesses will fit into this new emission class thereby reducing the financial impact on small businesses due to penalties.

The proposed amendments do not establish exemptions or differing requirements for small businesses. Therefore, those small businesses that are subject to the proposed new rules and related amendments may have continuous monitoring systems, reporting, recordkeeping, and testing requirements imposed on them which would subject them to these proposed penalty amendments.

In order to further minimize undue impacts on small businesses, the Department has proposed a two-tiered penalty section in the CMS Penalty Schedule for major and minor source operations, as defined by Tables 2A and 2B of N.J.A.C. 7:27-3.10(m). The penalties for minor source operations would be approximately one-quarter to one-half of the penalties for major source operations with CMS.

As a result of the changes to the definition of a major facilities in the CAAA of 1990, approximately 350 facilities that were not major facilities in the past will now be considered major facilities. Many of these facilities are small businesses. These facilities which had potential emissions of less than the former definition of a major facility, that is, 100 tons per year of VOC or NO_X, but which now have potential emissions of 25 tons per year or more of VOC or NO_x, be considered major facilities under this proposal. This would result in higher penalties for such major facilities that operate in noncompliance with their permits. These higher penalties are justified based on New Jersey's "severe" classification for ozone and the overall contribution of air contaminants from these facilities.

The Department is proposing penalties for violation of CMS recordkeeping and reporting requirements which are consistent with violations of similar requirements under N.J.A.C. 7:27-16 and the corresponding penalties in N.J.A.C. 7:27A-3. There is no distinction made between "major" and "minor" sources as in other places in the proposal. Failure to comply with the CMS recordkeeping and reporting requirements are significant violations because these records and reports are essential to determine the State's compliance efforts with the requirements of the CAAA of 1990. If a repeat violation of the CMS recordkeeping and reporting requirements has not occurred within five years of an earlier offense, the Department may treat the next offense as a first offense for penalty determination purposed in accordance with N.J.A.C. 7:27A-3.5(f).

Finally, the Department will establish a Small Business Assistance Program to minimize additional impacts on small businesses in completing their respective permit applications, assist in selecting control technology, and assist in developing alternative methods for monitoring, report-

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ing, recordkeeping, and testing requirements that will be the least costly to comply with New Jersey's air pollution control laws and regulations. (See companion proposal for N.J.A.C. 7:27-22.)

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:27A-3.2 Definitions

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise. Unless otherwise specified below, all words and terms are defined in N.J.S.A. 26:2C-2 and in N.J.A.C. 7:27.

. . .

"Continuous emissions monitor" or "CEM" means a device which continuously measures the emissions from one or more source operations.

"Continuous monitoring system" or "CMS" means a system designed to continuously measure various parameters at a facility which may affect or relate to a facility's emissions. Components of a CMS include, but are not limited to, any continuous emissions monitor (CEM), continuous opacity monitor (COM), continuous process monitor (CPM), or any other constantly operating measuring device and recording device approved by the Department to perform one or more of the functions of a CMS. Ambient monitors, which measure the impact or concentration of air contaminants emitted by the source operation or facility in nearby areas, are not considered part of a facility's CMS.

"Continuous opacity monitor" or "COM" means a device which continuously measures opacity of flue gases on a continuing basis.

"Continuous process monitor" or "CPM" means an instrument or system which continuously measures an operational parameter at a facility, such as temperature or air flow rate.

. . .

"HAP (Table A or B)" means hazardous air pollutant as defined in N.J.A.C. 7:27-22.

. . .

"Source operation" means any process, or any identifiable part thereof, that emits or can reasonably be anticipated to emit any air contaminant either directly or indirectly into the outdoor atmosphere. A source operation may include one or more pieces of equipment or control apparatus. This term includes the term "emissions unit" as defined at 40 CFR 70.2.

. . .

7:27A-3.5 Civil administrative penalty determination-general

(a)-(e) (No change.)

(f) **Except as provided for in (g) and (h) below,** [The] **the** Department may, in its discretion, treat an offense as a first offense solely for civil administrative penalty determination purposes, if the violator has not committed the same offense in the five years immediately preceding the date of the pending offense.

(g) For violations of N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(c) or (e) indicated by a continuous monitoring system, the Department shall calculate penalties in accordance with N.J.A.C. 7:27A-3.10(m)1 and may, in its discretion for purposes of determining the statutory maximum penalty for an offense, treat an offense as a first offense for civil administrative penalty determination purposes, at the beginning of each calendar quarter.

(h) For violations of N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(d) or (e) when a continuous monitoring system operates out of control or is out of service, the Department shall calculate penalties in accordance with N.J.A.C. 7:27A-3.10(m)2 and may, in its discretion, treat an offense as a first offense for civil administrative penalty determination purposes, if the violator has not committed the same offense in the year immediately preceding the date of the pending offense.

7:27A-3.10 Civil administrative penalties for violations of rules adopted pursuant to the Act

(a) The Department may assess a [civil] **civil** administrative penalty of not more than $10,000 for the first offense, not more than $25,000 for the second offense, and not more than $50,000 for the third and each subsequent offense for each violation of the Act, or of any rule promulgated pursuant to the Act listed in [(e) or (f)] **(l) and (m) below.**

(b)-(c) (No change.)

(d) **Except as provided for in (e) and (f) below,** [The] **the** Department may, in its discretion, treat an offense as a first offense solely for civil administrative penalty determination purposes, if the violator has not committed the same offense in the five years immediately preceding the date of the pending offense.

(e) For violations of N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(c) or (e) indicated by a continuous monitoring system, the Department shall calculate penalties in accordance with (m)1 below and may, in its discretion for purposes of determining the statutory maximum penalty for an offense, treat an offense as a first offense for civil administrative penalty determination purposes, at the beginning of each calendar quarter.

(f) For violations of N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(d) or (e) when a continuous monitoring system operates out of control or is out of service, the Department shall calculate penalties in accordance with (m)2 below and may, in its discretion, treat an offense as a first offense for civil administrative penalty determination purposes, if the violator has not committed the same offense in the year immediately preceding the date of the pending offense.

(g) Where the civil administrative penalty for a violation of the Act or of any rule promulgated pursuant to the Act may be determined by using more than one provision of this section, the Department may, in its discretion, assess the highest civil administrative penalty that corresponds to the violation, in order to provide a sufficient deterrent effect.

[(e)]**(h)** The Department shall determine the amount of the civil administrative penalty for offenses described in this section on the basis of the provision violated and the frequency of the violation. [Footnotes 3, 4, and 8 set forth in this subsection and (f) below are intended solely to put violators on notice that in addition to any civil administrative penalty assessed the Department may also revoke the violator's operating certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an operating certificate or variance, but merely indicate the situations in which the Department is most likely to see revocation. The number of the following subsections corresponds to the number of the corresponding subchapter in N.J.A.C. 7:27.]

(i) The Department may, in its discretion prior to assessment of a civil administrative penalty, adjust the amount of any penalty determined under this section pursuant to the factors listed in N.J.A.C. 7:27A-3.5.

(j) For violations of N.J.A.C. 7:27-22.3(a) and (b), the Department shall calculate penalties in accordance with the Civil Administrative Penalty Schedule in (l) below by adding the penalty amounts for each source operation within a facility that is subject to N.J.A.C. 7:27-22. The daily penalty for such violations shall not exceed the amounts set forth in (a) above.

(k) Footnotes 3, 4, and 8 set forth in the Civil Administrative Penalty Schedule in (l) below are intended solely to put violators on notice that in addition to assessing a civil administrative penalty, the Department may also revoke the violator's Operating Permit, Certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an Operating Permit, Certificate or variance, but merely to indicate the situations in which the Department would be most likely to seek revocation.

(l) The violations of N.J.A.C. 7:27 and the civil administrative penalty amounts for each violation, are as set forth in the following Civil Administrative Penalty Schedule. The numbers of the following subsections correspond to the numbers of the corresponding subchapter in N.J.A.C. 7:27. The rule summaries for the requirements set forth in the Civil Administrative Penalty Schedule in this subsection are provided for informational purposes only and have no legal effect.

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CIVIL ADMINISTRATIVE PENALTY SCHEDULE

1.-7. (No change.)

8. The violations of N.J.A.C. 7:27-8, **Preconstruction** Permits and Certificates, and the civil administrative penalty amounts for each violation, per source **operation,** are set forth in the following table:

Citation	**Rule Summary**	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(a)	**Obtain Preconstruction Permit**				
Class: Estimated Potential Emission Rate **of Source Operation**					
	1. Less than 0.5 pound per hour	**$100[5]**	**$200[5]**	**$500[5]**	**$1,500[5]**
	[1.]**2.** [Less than 10] **From 0.5 through 10** pounds per hour, **or 0.5 through 2.5 pounds per hour for VOC and NO_x**	$200[5]	$400[5]	$1,000[5]	$3,000[5]
	[2.]**3.** [Ten] **Greater than 10** through 22.8 pounds per hour, **or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x**	$600[5]	$1,200[5]	$3,000[5]	$9,000[5]
	[3.]**4.** Greater than 22.8 pounds per hour, **or greater than 5.7 pounds per hour for VOC and NO_x**	$1,000[5]	$2,000[5]	$5,000[5]	$15,000[5]
	[4.]**5.** Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, [EHS,] TXS **and HAP (Table A or B)[6]**	$2,000	$4,000	$10,000	$30,000

Citation	**Rule Summary**	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(b)	**Obtain Certificate**				
Class: Estimated Potential Emission Rate **of Source Operation**					
	1. Less than 0.5 pound per hour	**$100[5]**	**$200[5]**	**$500[5]**	**$1,500[5]**
	[1.]**2.** [Less than 10] **From 0.5 through 10** pounds per hour, **or 0.5 through 2.5 pounds per hour for VOC and NO_x**	$200[5]	$400[5]	$1,000[5]	$3,000[5]
	[2.]**3.** [Ten] **Greater than 10** through 22.8 pounds per hour, **or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x**	$600[5]	$1,200[5]	$3,000[5]	$9,000[5]
	[3.]**4.** Greater than 22.8 pounds per hour, **or greater than 5.7 pounds per hour for VOC and NO_x**	$1,000[5]	$2,000[5]	$5,000[5]	$15,000[5]
	[4.]**5.** Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, [EHS,] TXS **and HAP (Table A or B)[6]**	$2,000	$4,000	$10,000	$30,000

Citation	[Class] **Rule Summary**	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(d)	[All] **Preconstruction Permit or Certificate Readily Available**	$100	$200	$500	$1,500

Citation	**Rule Summary**	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(e)[1]	**Emissions Detected by Stack Tests from Source Operation**				
Class: Maximum [Actual] **Allowable** Emissions					
	Less than 0.5 pound per hour:				
	1. Less than 25 percent over the allowable standard	**$500[4]**	**$1,000[4]**	**$2,500[4]**	**$7,500[4]**
	2. From 25 through 50 percent over the allowable standard	**$1,000[4]**	**$2,000[4]**	**$5,000[4]**	**$15,000[4]**
	3. Greater than 50 percent over the allowable standard	**$2,000[4]**	**$4,000[4]**	**$10,000[4]**	**$30,000[4]**
	[For less than 10] **From 0.5 through 10** pounds per hour, **or 0.5 through 2.5 pounds per hour for VOC and NO_x:**				
	1. Less than 25 percent over the allowable standard	$2,000[4]	$4,000[4]	$10,000[4]	$30,000[4]
	2. From 25 through 50 percent over the allowable standard	$4,000[4]	$8,000[4]	$20,000[4]	$50,000[4]

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3. Greater than 50 percent over the allowable standard	$8,000[4]	$16,000[4]	$40,000[4]	$50,000[4]
[From 10 pounds] **Greater than 10** through 22.8 pounds per hour, **or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x:**				
1. Less than 25 percent over the allowable standard	$6,000[4]	$12,000[4]	$30,000[4]	$50,000[4]
2. From 25 through 50 percent over the allowable standard	$8,000[4]	$16,000[4]	$40,000[4]	$50,000[4]
3. Greater than 50 percent over the allowable standard	$10,000[4]	$20,000[4]	$50,000[4]	$50,000[4]
For greater than 22.8 pounds per hour, **or greater than 5.7 pounds per hour for VOC and NO_x or air contaminants regulated pursuant to HAP (Table A or B):**				
1. Less than 25 percent over the allowable standard	$8,000[4]	$16,000[4]	$40,000[4]	$50,000[4]
2. From 25 through 50 percent over the allowable standard	$10,000[4]	$20,000[4]	$50,000[4]	$50,000[4]
3. Greater than 50 percent over the allowable standard	$10,000[4]	$20,000[4]	$50,000[4]	$50,000[4]

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(e)[1 or (e)2]	**Preconstruction Permit and Certificate Conditions and Provisions**				
Class: Emissions **from Source Operation**					
1. Less than 0.5 pound per hour		**$400[5]**	**$800[5]**	**$2,000[5]**	**$6,000[5]**
[1.]**2.** [Less than] **From 0.5 through** 10 pounds per hour, **or 0.5 through 2.5 pounds per hour for VOC and NO_x**		$800[5]	$1,600[5]	$4,000[5]	$12,000[5]
[2.]**3.** [From 10] **Greater than 10** through 22.8 pounds per hour, **or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x**		$1,200[5]	$2,400[5]	$6,000[5]	$18,000[5]
[3.]**4.** Greater than 22.8 pounds per hour, **or greater than 5.7 pounds per hour for VOC and NO_x**		$2,000[5]	$4,000[5]	$10,000[5]	$30,000[5]
[4.]**5.** Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, [EHS,] TXS **and HAP (Table A or B)[6]**		$3,000	$6,000	$15,000	$45,000

Citation	**Rule Summary**
N.J.A.C. 7:27-8.3(e)	**Preconstruction Permit and Certificate Conditions and Provisions Detected by Continuous Monitoring System**

*** See N.J.A.C. 7:27A-3.10(m) for the calculation of civil administrative penalties[5]**

Citation	**Rule Summary**	**First Offense**	**Second Offense**	**Third Offense**	**Fourth and Each Subsequent Offense**
N.J.A.C. 7:27-8.4(c)1	**Submit Source Specific Testing Protocol**	**$11,000**	**$12,000**	**$15,000**	**$15,000**
N.J.A.C. 7:27-8.4(c)3	**Conduct Source Specific Testing**	**$2,000**	**$4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-8.4(c)4	**Provide Notice of Source Specific Testing**	**$300**	**$600**	**$1,500**	**$4,500**
N.J.A.C. 7:27-8.4(c)5	**Submit Test Report**	**$500**	**$1,000**	**$2,500**	**$5,000**
N.J.A.C. 7:27-8.4(c)6	**Certify Test Report**	**$300**	**$600**	**$1,500**	**$4,500**
N.J.A.C. 7:27-8.4(f)	**Conduct Air Quality Impact Analysis**	**$2,000**	**$4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-8.4(g)	**Submit Application for Renewal**	**$200**	**$400**	**$1,000**	**$3,000**
N.J.A.C. 7:27-8.4(j)	**Conduct Air Quality Impact Analysis**	**$2,000**	**$4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-8.9(a)	**Submit Records**	**$500**	**$1,000**	**$2,500**	**$7,500**
N.J.A.C. 7:27-8.9(b)	**Submit Report**	**$500**	**$1,000**	**$2,500**	**$7,500**
N.J.A.C. 7:27-8.9(c)	**Certify Report**	**$300**	**$600**	**$1,500**	**$4,500**
N.J.A.C. 7:27-8.9(d)	**Submit Emission Report**	**$500**	**$1,000**	**$2,500**	**$7,500**
N.J.A.C. 7:27-8.14(d)	**Submit Notification of Administrative Amendment**	**$200**	**$400**	**$1,000**	**$3,000**

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N.J.A.C. 7:27-8.15(d)	Provide Seven-Day-Notice	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-8.15(k)	Maintain Record of Seven-Day-Notice	$100	$200	$500	$1,500
N.J.A.C. 7:27-8.16(c)	Apply for and Receive Approval Prior to Making an Alteration	$800	$1,600	$4,000	$12,000
N.J.A.C. 7:27-8.17(b)	Submit Seven-Day Notice and Documentation of Alteration for Facilities Subject to Pollution Prevention Act	$300	$600	$1,500	$4,500

[4]Per Air Contaminant Exceeding Allowable Standard—Revoke Certificate to Operate Under N.J.A.C. 7:27-8 **or Revoke Operating Permit Under N.J.A.C. 7:27-22** (if applicable)

[5]Based on Permit, if Applicable, or if Not, Estimate of Air Contaminant with Greatest Emission Rate Without Controls

[6]NSPS (40 CFR 60) EOR (N.J.A.C. 7:27-18)
NESHAPS (40 CFR 61) TXS (N.J.A.C. 7:27-17)
PSDAQ (40 CFR 51) [EHS N.J.A.C. 7:31] **HAP (TABLE A OR B) (N.J.A.C. 7:27-22)**

[11]Calculate penalty in accordance with N.J.A.C. 7:27-8.15(h)

9.-21. (No change.)

22. The violations of N.J.A.C. 7:27-22, Operating Permits, and the civil administrative penalty amounts for each violation, per source operation, are set forth in the following tables:

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.3(a)	Obtain and Maintain Operating Permit				
Class: Estimated Potential Emission of Source Operation					
1.	Less than 0.5 pound per hour	$100[10]	$200[10]	$500[10]	$1,500[10]
2.	From 0.5 through 10 pounds per hour, or 0.5 through 2.5 pounds per hour for VOC and NO_x	$200[10]	$400[10]	$1,000[10]	$3,000[10]
3.	Greater than 10 through 22.8 pounds per hour, or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x	$600[10]	$1,200[10]	$3,000[10]	$9,000[10]
4.	Greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x	$1,000[10]	$2,000[10]	$5,000[10]	$15,000[10]
5.	Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, TXS and HAP (Table A or B)[6]	$2,000	$4,000	$10,000	$30,000

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.3(b)	Obtain Operating Permit Before Operation				
Class: Estimated Potential Emission of Source Operation					
1.	Less than 0.5 pound per hour	$100[10]	$200[10]	$500[10]	$1,500[10]
2.	From 0.5 through 10 pounds per hour, or 0.5 through 2.5 pounds per hour for VOC and NO_x	$200[10]	$400[10]	$1,000[10]	$3,000[10]
3.	Greater than 10 through 22.8 pounds per hour, or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x	$600[10]	$1,200[10]	$3,000[10]	$9,000[10]
4.	Greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x	$1,000[10]	$2,000[10]	$5,000[10]	$15,000[10]
5.	Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, TXS and HAP (Table A or B)[6]	$2,000	$4,000	$10,000	$30,000

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.3(c)	Emissions Not Detected by Continuous Monitoring System (See Below) or Stack Test (See Below)				
N.J.A.C. 7:27-22.3(d)	Proper Operation and				
N.J.A.C. 7:27-22.3(e)	Other Conditions				

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Class: Emission of Source Operation				
1. Less than 0.5 pound per hour	$400[10]	$800[10]	$2,000[10]	$6,000[10]
2. From 0.5 through 10 pounds per hour, or 0.5 through 2.5 pounds per hour for VOC and NO_x	$800[10]	$1,600[10]	$4,000[10]	$12,000[10]
3. Greater than 10 through 22.8 pounds per hour, or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x	$1,200[10]	$2,400[10]	$6,000[10]	$18,000[10]
4. Greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x	$2,000[10]	$4,000[10]	$10,000[10]	$30,000[10]
5. Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, TXS and HAP (Table A or B)[6]	$3,000	$6,000	$15,000	$45,000

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.3(c)	Emissions Detected by Stack Test				
Class: Maximum Allowable Emission of Source Operation					
	Less than 0.5 pound per hour:				
	1. Less than 25 percent over the allowable standard	$500[4]	$1,000[4]	$2,500[4]	$7,500[4]
	2. From 25 through 50 percent over the allowable standard	$1,000[4]	$2,000[4]	$5,000[4]	$15,000[4]
	3. Greater than 50 percent over the allowable standard	$2,000[4]	$4,000[4]	$10,000[4]	$30,000[4]
	From 0.5 through 10 pounds per hour, or 0.5 through 2.5 pounds per hour for VOC and NO_x:				
	1. Less than 25 percent over the allowable standard	$2,000[4]	$4,000[4]	$10,000[4]	$30,000[4]
	2. From 25 through 50 percent over the allowable standard	$4,000[4]	$8,000[4]	$20,000[4]	$50,000[4]
	3. Greater than 50 percent over the allowable standard	$8,000[4]	$16,000[4]	$40,000[4]	$50,000[4]
	Greater than 10 pounds through 22.8 pounds per hour, or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x:				
	1. Less than 25 percent over the allowable standard	$6,000[4]	$12,000[4]	$30,000[4]	$50,000[4]
	2. From 25 through 50 percent over the allowable standard	$8,000[4]	$16,000[4]	$40,000[4]	$50,000[4]
	3. Greater than 50 percent over the allowable standard	$10,000[4]	$20,000	$50,000[4]	$50,000[4]
	Greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x, or air contaminants regulated pursuant to HAP (Table A or B):				
	1. Less than 25 percent over the allowable standard	$8,000[4]	$16,000[4]	$40,000[4]	$50,000[4]
	2. From 25 through 50 percent over the allowable standard	$10,000[4]	$20,000[4]	$50,000[4]	$50,000[4]
	3. Greater than 50 percent over the allowable standard	$10,000[4]	$20,000[4]	$50,000[4]	$50,000[4]

Citation	Rule Summary
N.J.A.C. 7:27-22.3(c)	Emissions Detected by Continuous Monitoring System
N.J.A.C. 7:27-22.3(e)	Operating Parameters Detected by Continuous Monitoring System

Class: Continuous Monitoring Systems

* See N.J.A.C. 7:27A-3.10(m) for the calculation of civil administrative penalties.[10]

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.3(q)	Certify Report	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-22.5(b)	Submit Application for Operating Permit	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-22.8(a)	Perform Modeling/Risk Assessment for Initial Operating Permit	$2,000	$4,000	$10,000	$30,000

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N.J.A.C. 7:27-22.8(d)	Perform Modeling/Risk Assessment for Renewal	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-22.8(e)	Perform Modeling/Risk Assessment for Significant Modification	$2,000	$4,000	$10,000	$30,000

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.9(a)	Submit Proposed Compliance Plan for Operating Permit				
Class					
1. Plan Not Submitted		$1,000	$2,000	$5,000	$15,000
2. Plan Incomplete		$500	$1,000	$2,500	$7,500

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.9(b)	Submit Proposed Compliance Plan for Renewal of and Significant and Minor Modifications to Operating Permit				
Class					
1. Plan Not Submitted		$1,000	$2,000	$5,000	$15,000
2. Plan Incomplete		$500	$1,000	$2,500	$7,500

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.14(d)	General Operating Permit Terms and Conditions				
Class: Estimated Potential Emission Rate of Source Operation					
1. Less than 0.5 pound per hour		$400[10]	$800[10]	$2,000[10]	$6,000[10]
2. From 0.5 through 10 pounds per hour, or 0.5 through 2.5 pounds per hour for VOC and NO_x		$800[10]	$1,600[10]	$4,000[10]	$12,000[10]
3. Greater than 10 through 22.8 pounds per hour, or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x		$1,200[10]	$2,400[10]	$6,000[10]	$18,000[10]
4. Greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x		$2,000[10]	$4,000[10]	$10,000[10]	$30,000[10]
5. Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, EHS, TXS and HAP (Table A or B)[6]		$3,000	$6,000	$15,000	$45,000

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.15(b)1	Temporary Facility Operating Permit Requirements				
Class: Emission of Source Operation					
1. Less than 0.5 pound per hour		$400[10]	$800[10]	$2,000[10]	$6,000[10]
2. From 0.5 through 10 pounds per hour, or 0.5 through 2.5 pounds per hour for VOC and NO_x		$800[10]	$1,600[10]	$4,000[10]	$12,000[10]
3. Greater than 10 through 22.8 pounds per hour, or greater than 2.5 through 5.7 pounds per hour for VOC and NO_x		$1,200[10]	$2,400[10]	$6,000[10]	$18,000[10]
4. Greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x		$2,000[10]	$4,000[10]	$10,000[10]	$30,000[10]
5. Regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, TXS and HAP (Table A or B)[6]		$3,000	$6,000	$15,000	$45,000

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Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-22.15(b)3	Provide Written Notice of Change	$200	$400	$1,000	$3,000
N.J.A.C. 7:27-22.18(b)	Submit Source Emission Testing and Monitoring Protocol	$1,000	$2,000	$5,000	$15,000
N.J.A.C. 7:27-22.18(d)	Resubmit Source Emission Testing and Monitoring Protocol	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.18(e)1	Schedule Source Emission Testing Date	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-22.18(e)2	Perform Source Emissions Testing	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-22.18(e)3	Submit Source Emissions Test Report	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.18(f)	Perform Periodic Source Emissions Testing	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-22.18(g)3	Schedule Performance Specification Test Date	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-22.18(g)4	Conduct Performance Specification Test	$1,000	$2,000	$5,000	$15,000
N.J.A.C. 7:27-22.18(g)5	Submit Performance Specification Report	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.18(h)	Certify Source Emissions Test Report or Performance Specification Test Report	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-22.19(a)	Maintain Records of Source Emissions Testing or Monitoring	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.19(c)	Submit Source Emissions Testing and Monitoring Reports	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.19(f)	Submit Periodic Compliance Certification	$1,000	$2,000	$5,000	$15,000
N.J.A.C. 7:27-22.19(h)	Submit Operating Permit or Emissions Records	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.19(i)	Make Information Readily Available	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.19(g)2	Report Air Contaminant Release Not Subject to N.J.S.A. 26:2C-19(e)	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-22.20(c)	Submit Application for Administrative Amendment	$200	$400	$1,000	$3,000
N.J.A.C. 7:27-22.21(c)	Maintain Log of Insignificant Source Operation Changes	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.22(d)	Provide Seven-Day-Notice	$300[12]	$600[12]	$1,500[12]	$4,500[12]
N.J.A.C. 7:27-22.22(l)	Maintain Record of Seven-Day-Notice	$100	$200	$500	$1,500
N.J.A.C. 7:27-22.23(b)	Submit Application for Minor Modification	$800	$1,600	$4,000	$12,000
N.J.A.C. 7:27-22.23(d)	Submit Application for Minor Modification	$800	$1,600	$4,000	$12,000
N.J.A.C. 7:27-22.24(a)	Apply for and Receive Approval Prior to Making Significant Modification	$3,000	$6,000	$15,000	$45,000
N.J.A.C. 7:27-22.25(b)	Furnish Operating Permit Modification Information	$300	$600	$1,500	$4,500
N.J.A.C. 7:27-22.26(d)	Submit Application to Incorporate Maximum Achievable Control Technology Standard or Generally Available Control Technology Standard on Operating Permit	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-22.26(k)	Achieve Compliance with Maximum Achievable Control Technology Standard or Generally Available Control Technology Standard	$3,000	$6,000	$15,000	$45,000
N.J.A.C. 7:27-22.26(p)	Achieve Compliance (Facility Subject to Case-by-Case Maximum Achievable Control Technology Standard)	$3,000	$6,000	$15,000	$45,000
N.J.A.C. 7:27-22.27(c)	Maintain Log for Alternative Operating Scenarios	$500	$1,000	$2,500	$7,500

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N.J.A.C. 7:27-22.28(i)	Maintain Emissions Trading Log	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-22.30(b)	Submit Application for Renewal of Operating Permit	$2,000	$4,000	$10,000	$30,000

[4]Per Air Contaminant Exceeding Allowable Standard—Revoke Certificate to Operate Under N.J.A.C. 7:27-8 or Revoke Operating Permit Under N.J.A.C. 7:27-22 (if applicable).

[6]NSPS (40 CFR 60) EOR (N.J.A.C. 7:27-18)
NESHAPS (40 CFR 61) TXS (N.J.A.C. 7:27-17)
PSDAQ (40 CFR 51) HAP Table A or B (N.J.A.C. 7:27-22)

[10]Based on each Preconstruction Permit incorporated into the Operating Permit, if applicable, or if not, estimate of air contaminants with the stated emission rate without controls.

[12]Calculate penalty in accordance with N.J.A.C. 7:27-22.22(i).

23.-25. (No change.)

(m) The Department shall determine the amount of civil administrative penalty for violations of N.J.A.C. 7:27-8 and 7:27-22 as follows: for violations detected by continuous monitoring systems in accordance with (m)1 below; for continuous monitoring systems not installed, out of service or out of control in accordance with (m)2 below; and for violations of continuous monitoring systems recordkeeping and reporting requirements in accordance with (m)3 below. The rule summaries for the requirements set forth in the Civil Administrative Penalty Schedule in this subsection are provided for informational purposes only and have no legal effect.

1. The Department shall determine the amount of civil administrative penalty for violations of N.J.A.C. 7:27-8.3(e) and 7:27-22.3(c) and (e) as indicated by continuous monitoring systems on the basis of the severity level, duration of the offense and the size or nature of the source operation associated with the violation as follows:

i. Table 1 of this section shall be used to determine the level of offense, based on the percentage or amount of differential from the standard or allowable set forth in the Preconstruction Permit or Operating Certificate issued pursuant to N.J.A.C. 7:27-8 or Operating Permit issued pursuant to N.J.A.C. 7:27-22.

ii. Tables 2A or 2B of this section shall be used to determine the amount of the base penalty. The level of offense determined from Table 1 is used in conjunction with either Table 2A (for any major source operation) or Table 2B (for any minor source operation) as defined in the corresponding footnotes below Tables 2A and 2B.

iii. Table 3 shall be used to determine a multiplier which shall be applied to the base penalty from either Table 2A or 2B. The multipliers included in Table 3 each correspond to the duration of the offense or the length of the averaging time provided in the Preconstruction Permit or Operating Certificate issued pursuant to N.J.A.C. 7:27-8 or Operating Permit issued pursuant to N.J.A.C. 7:27-22. The base penalty determined from Table 2A or 2B is multiplied by the appropriate Table 3 multiplier to determine the penalty amount of the offense.

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CONTINUOUS MONITORING SYSTEMS[7]

TABLE 1

	CONTINUOUS EMISSION MONITORS		CONTINUOUS PROCESS MONITORS			
LEVEL OF OFFENSE	AIR CONTAMINANTS (% above allowable emission rate or concentration)	OPACITY	OXYGEN (%)	pH	TEMPERATURE[1] degrees Rankine (°F + 460)	OTHER MINIMUM OR MAXIMUM SPECIFICATIONS[2]
LEVEL I	Greater than 0% up to and including 25%	Greater than the standard up to and including 20%	75% to less than 100% of the minimum oxygen concentration	pH differential of less than 2	Any deviation greater than 0% up to and including 5% of the standard	Any deviation greater than 0% up to and including 25% of the standard
LEVEL II	Greater than 25% up to and including 50%	Greater than 20% up to and including 40%	50% to less than 75% of the minimum oxygen concentration	pH differential of 2 through 5	Any deviation greater than 5% up to and including 15% of the standard	Any deviation greater than 25% up to and including 50% of the standard
LEVEL III	Greater than 50%	Greater than 40%	Less than 50% of the minimum oxygen concentration	pH differential of greater than 5	Any deviation greater than 15% of the standard	Any deviation greater than 50% of the standard

[1] If applicable, use Level of Offense established in the Preconstruction Permit or Operating Certificate issued pursuant to N.J.A.C. 7:27-8 or Operating Permit issued pursuant to N.J.A.C. 7:27-22, if different from Table 1.

[2] e.g., Pressure Drop, Flow Rate, Oxidation Reduction Potential, etc.

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CONTINUOUS MONITORING SYSTEMS

TABLE 2A
MAJOR SOURCE OPERATION[3]

LEVEL	BASE PENALTY
I	$200
II	$400
III	$1,000

TABLE 3

AVERAGING TIME OR DURATION	MULTIPLIER
≤ 30 minutes	1
> 30 min & ≤ 1 hr	2
> 1 hr & ≤ 3 hr	4
> 3 hr & ≤ 8 hr	6
> 8 hr & ≤ 24 hr	8
> 24 hr	10

TABLE 2B
MINOR SOURCE OPERATION[4]

LEVEL	BASE PENALTY
I	$100
II	$200
III	$500

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[3] Any source operation with estimated potential emissions without control of greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x, or air contaminants regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, TXS, and HAPS (Table A or B) based on a Preconstruction Permit or Certificate issued pursuant to N.J.A.C. 7:27-8 or on an Operating Permit issued pursuant to N.J.A.C. 7:27-22.

[4] Any source operation with estimated potential emissions without control of 22.8 pounds per hour or less, or 5.7 pounds per hour or less for VOC and NO_x based on a Preconstruction Permit or Certificate issued pursuant to N.J.A.C. 7:27-8 or on an Operating Certificate issued pursuant to N.J.A.C. 7:27-22.

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2. The violations of N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(d) or (e) for continuous monitoring systems not installed, out of service or out of control and the civil administrative penalty amounts for each violation are set forth in the following Table:

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(d) and (e)	Continuous Monitoring Systems Not Installed, Out of Service, Or Out of Control				
Class:					
1. Major Source Operation[3]					
Each day through day five[5]		$200[6]	$400[6]	$1,000[6]	$3,000[6]
Day six and each subsequent day thereafter[5]		$500[6]	$1,000[6]	$2,500[6]	$7,500[6]
2. Minor Source Operation[4]					
Each day through day five[5]		$100[6]	$200[6]	$500[6]	$1,500[6]
Day six and each subsequent day thereafter[5]		$250[6]	$500[6]	$1,250[6]	$3,750[6]

3. The violations of N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(e) for continuous monitoring systems recordkeeping and reporting requirements and the civil administrative penalty amounts for each violation are set forth in the following Table:

Citation	Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-8.3(e) and N.J.A.C. 7:27-22.3(e)	Comply with Preconstruction Permit, Certificate and Operating Certificate Requirements for Continuous Monitoring Systems				
Class:					
1. Keep Records[5]		$500[6]	$1,000[6]	$2,500[6]	$7,500[6]
2. Submit Reports[5]		$300[6]	$600[6]	$1,500[6]	$4,500[6]

[3]Any source operation with estimated potential emissions without controls of greater than 22.8 pounds per hour, or greater than 5.7 pounds per hour for VOC and NO_x, or air contaminants regulated pursuant to NSPS, NESHAPS, PSDAQ, EOR, TXS and HAP (Table A or B) based on Preconstruction Permit or Certificate issued pursuant to N.J.A.C. 7:27-8 or Operating Permit issued pursuant to N.J.A.C. 7:22.

[4]Any source operation with estimated potential emissions without controls of 22.8 pounds per hour or less, or 5.7 pounds per hour or less for VOC and NO_x, based on a Preconstruction Permit or Certificate issued pursuant to N.J.A.C. 7:27-8 or an Operating Permit issued pursuant to N.J.A.C. 7:27-22.

[5]Number of days after subtracting downtime allowance pursuant to N.J.A.C. 7:27-1, or a Preconstruction Permit or Certificate issued pursuant to N.J.A.C. 7:27-8 or an Operating Permit issued to N.J.A.C. 7:27-22.

[6]Per continuous monitor

[7]For instance, a Preconstruction Permit and Operating Certificate issued pursuant to N.J.A.C. 7:27-8 or an Operating Permit issued pursuant to N.J.A.C. 7:27-22 requires that for any 1-hour period, the average concentration of nitrogen oxides (NO_x) in the stack gas shall not exceed 300 parts per million by volume as determined by continuous monitoring. A violator emitted NO_x from a major source operation at an hourly averaged concentration rate of 350 parts per million by volume. Using Table 1, determine the level of offense for the air contaminant (NO_x). Because the violator emitted NO_x at a concentration less than 25% above the allowable, the Level of Offense is Level I. The source operation is considered major because it emits NO_x in excess of 5.7 pounds per hour. Using Table 2A for a major source operation, determine the base penalty that corresponds to Level I. The base penalty for a Level I offense for a major source operation is $200. Using Table 3, determine the multiplier corresponding to a 1 hour averaging time. Multiply $200 by 2, the multiplier from Table 3. The penalty for the offense is $400.

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RULE ADOPTIONS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Special Hearing Rules
Division of Consumer Affairs
Lemon Law Hearings

Adopted Amendments: N.J.A.C. 1:13A-1.1, 14.2, 14.4, 18.1 and 18.3

Proposed: June 21, 1993 at 25 N.J.R. 2625(a).
Adopted: August 2, 1993 by Jaynee LaVecchia, Director, Office of Administrative Law.
Filed: August 2, 1993 as R.1993 d.422, **without change.**
Authority: N.J.S.A. 52:14F-5(e), (f) and (g).
Effective Date: September 7, 1993.
Expiration Date: April 3, 1994.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

1:13A-1.1 Applicability
The special rules in this chapter shall apply to matters transmitted to the Office of Administrative Law (OAL) by the Division of Consumer Affairs (Division) wherein a consumer of a motor vehicle seeks a refund or replacement of the vehicle from a manufacturer under the provisions of the New Jersey Lemon Law, N.J.S.A. 56:12-29 et seq. These special rules must be read in conjunction with the Division of Consumer Affairs' rules on dispute resolution at N.J.A.C. 13:45A-26.1 through 26.17. Any aspect of the OAL hearing not covered by these special hearing rules shall be governed by the Uniform Administrative Procedure Rules (U.A.P.R.) contained in N.J.A.C. 1:1. To the extent that these special rules are inconsistent with the U.A.P.R., these rules shall apply.

1:13A-14.2 Conduct of hearing
(a) (No change.)
(b) There shall be no proposed findings of fact, conclusions of law, briefs, forms of order or other posthearing submissions permitted after the final argument except if permitted by the judge for good cause. In no event shall the submission of posthearing documents extend the 20 days permitted for issuing an initial decision.

1:13A-14.4 Proof of fees and costs
(a) (No change.)
(b) A prevailing consumer shall be awarded the following fees and costs: reasonable attorney's fees, filing fee, fees for reports prepared by expert witnesses or for the appearance and testimony of expert witnesses.

1:13A-18.1 Initial decisions
(a) An initial decision shall be issued in writing no later than 20 days from the conclusion of the hearing.
(b)-(d) (No change.)

1:13A-18.3 Final decision
The Director of the Division of Consumer Affairs shall issue a final decision which shall adopt, reject or modify the initial decision no later than 15 days from receipt of the initial decision. Unless a final decision is issued within the 15 day period, the initial decision shall be deemed adopted as the final decision and the requirements and penalties of N.J.A.C. 13:45A-26.12(c) and (d) and N.J.A.C. 13:45A-26.13 shall apply.

BANKING

(b)

DIVISION OF REGULATORY AFFAIRS

Attorney Fees; Cancellation Charge; Advertising; Conversions among Mortgage Bankers, Mortgage Bankers Non-Servicing and Mortgage Brokers

Adopted Amendments: N.J.A.C. 3:1-16.2 and 16.3; 3:2-1.4; 3:38-1.3 and 4.1

Proposed: June 21, 1993 at 25 N.J.R. 2625(b).
Adopted: August 2, 1993 by Stephen J. Szabatin, Acting Commissioner, Department of Banking.
Filed: August 4, 1993 as R.1993 d.423, **with substantive and technical changes** not requiring additional public notice and comment (See N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 17:1-8 and 8.1; 17:11B-13; 46:10A-6; and 46:18-11.2.
Effective Date: September 7, 1993.
Expiration Date: January 4, 1996, N.J.A.C. 3:1;
April 12, 1995, N.J.A.C. 3:2;
September 11, 1997, N.J.A.C. 3:38.

Summary of Public Comments and Agency Responses:
A comment was received from Robert DiConsiglio on behalf of the League of Mortgage Lenders. The commenter first supported the change in the advertising requirement from "mortgage banker non-servicing" to "mortgage banker n.s." The commenter stated that this change would inform the public as to a lender's regulatory category without implying that the lender has an inferior product to offer. The Department agrees and has adopted this proposed amendment.
In addition, the commenter suggested a change in the advertising disclosures for mortgage bankers non-servicing. Rather than disclosing as proposed that New Jersey law prohibited such licensees from holding or servicing such loans for more than 90 days in the regular course of business, the commenter suggested that the licensee merely disclose that it does not hold or service these loans in the regular course, without specific reference to New Jersey law. The Department agrees and makes this minor substantive change upon adoption.

Full text of the adoption follows (additions to the proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

3:1-16.2 Fees
(a) No lender shall charge a borrower any fees incident to the origination, processing or closing of a mortgage loan other than the following, except as otherwise authorized by State or Federal law, either explicitly or as interpreted by the appropriate regulator in official staff commentary, regulatory bulletins, or memoranda.
1.-6. (No change.)
7. Third party fees: Limited to the following fees paid or actually incurred by a lender on behalf of a borrower:
i.-iv. (No change.)
v. Outside counsels' fees as permitted by N.J.S.A. 46:10A-6;
vi.-xiii. (No change.)
xiv. Radon test fees; and
xv. (No change in text.)
8. (No change.)
9. A service fee not to exceed $25.00 to cancel the mortgage, providing that the borrower has received prior written notice of the fee required by the lender, and providing further that if the lender collects the service fee at the time of the mortgage transaction and transfers the servicing rights prior to cancellation, the lender shall refund the service fee to the borrower.
(b)-(c) (No change.)

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3:1-16.3 Application process

(a) Before a lender or broker accepts any application fee in whole or in part, any credit report fee, appraisal fee or any fee charged as reimbursement for third party fees, the lender or broker shall make written disclosure to the borrower (which disclosure may be contained in the application) as required by this section or N.J.A.C. 3:1-16.10, respectively, setting forth:

1.-3. (No change.)

4. A realistic estimate of the number of calendar days required to issue a commitment following receipt of such fees by the lender. If the lender subsequently determines that the estimate is unrealistic, it may return the application and all fees paid and offer the borrower the opportunity to reapply subject to a new estimate;

5. The name or title of a person within the lender's organization to whom the borrower may address written questions, comments, or complaints and who will be required to promptly respond to such inquiries; and

6. For mortgage bankers non-servicing, a statement indicating that the licensee is a mortgage banker non-servicing and *[is thereby prohibited by New Jersey law from holding]* ***as such does not hold*** mortgage loans or *[servicing]* ***service*** mortgage loans for more than 90 days in the regular course of business.

(b)-(e) (No change.)

3:2-1.4 Violations of the Act

(a) (No change.)

(b) Without limiting (a) above, the following conduct shall be deemed deceptive or misleading:

1.-5. (No change.)

6. The advertisement of a mortgage loan or mortgage loan services by a mortgage banker or mortgage broker without including in the advertisement or broadcast announcement the words "licensed mortgage banker—N.J. Department of Banking", "licensed mortgage banker n.s.—N.J. Department of Banking" for a non-servicing mortgage banker or "licensed mortgage broker—N.J. Department of Banking," whichever the case may be; and

7. (No change.)

(c)-(d) (No change.)

3:38-1.3 Applications

(a)-(f) (No change.)

(g) A licensee shall submit the following to convert from a mortgage banker to a mortgage banker non-servicing or from a mortgage banker non-servicing to a mortgage banker;

1. The original license, and the licenses of all branch offices;

2. A completed conversion form, which shall include the name and address of the licensee, the requested date of conversion and a copy of the licensee's most recent semi-annual report of tangible net worth filed pursuant to N.J.A.C. 3:38-1.10;

3. For a conversion to a mortgage banker non-servicing, a signed affidavit from the president, a general partner or the sole proprietor stating that the licensee will not hold or service mortgage loans for more than 90 days in the regular course of business; and

4. A conversion fee of $200.00 plus $25.00 for each additional branch office.

(h) A licensee shall submit the following to convert from a mortgage banker or a mortgage banker non-servicing to a mortgage broker, or from a mortgage broker to a mortgage banker or a mortgage banker non-servicing:

1. The original license, the licenses of all branch offices and the licenses of all licensed individuals;

2. A completed conversion form, which shall include the name and address of the licensee, the requested date of conversion and a copy of the licensee's most recent semi-annual report of tangible net worth filed pursuant to N.J.A.C. 3:38-1.10;

3. For a conversion to a mortgage broker, a signed affidavit from the president, a general partner or the sole proprietor stating that the licensee will not issue commitments or lock-ins in its name, will not close mortgage loans in its name, and will only charge borrowers application fees and discount points; and

4. A conversion fee of $200.00, plus $25.00 for each additional branch office and for each licensed individual.

(i) The Department shall approve a conversion of a license pursuant to (g) or (h) above so long as the licensee satisfies the tangible net worth requirement for the license sought, or the license sought has the same or a lesser tangible net worth requirement as the tangible net worth requirement of the license held by the licensee.

3:38-4.1 Fees permitted

(a) No licensee shall charge a borrower any fees incident to the origination, processing or closing of a mortgage loan other than the following, except as otherwise authorized by State or Federal law, either explicitly or as interpreted by the appropriate regulator in official staff commentary, regulatory bulletins, or memoranda.

1.-6. (No change.)

7. Discount points or fractions thereof;

8. Lock-in fees; and

9. A service fee not to exceed $25.00 to cancel the mortgage, providing that the borrower has received prior written notice of the fee required by the licensee, and providing further that if the licensee collects the service fee at the time of the mortgage transaction and transfers the servicing rights prior to cancellation, the licensee shall refund the service fee to the borrower.

(b)-(d) (No change.)

PERSONNEL

(a)

MERIT SYSTEM BOARD

Classification, Services and Compensation

Readoption with Amendments: N.J.A.C. 4A:3

Proposed: May 17, 1993 at 25 N.J.R. 1916(a).

Adopted: July 30, 1993 by the Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Filed: August 5, 1993 as R.1993 d.424, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 11A:2-6(d), 11A:2-11(h), 11A:3-1 through 7, and 11A:6-24; 29 U.S.C. 201, et seq.; and Executive Order No. 70(1992).

Effective Date: August 5, 1993, Readoption;
September 7, 1993, Amendments.

Expiration Date: August 5, 1998.

Summary of Hearing Officer Recommendations and Agency Responses:

A public hearing on the proposed readoption with amendments was held on June 3, 1993. Henry Maurer served as hearing officer. Three persons presented comments at that time. In addition, five persons submitted written comments. Mr. Maurer recommended that the rules be readopted with the amendments proposed, with changes as described in the Summary below. The record of the public hearing may be reviewed by contacting Janet Share Zatz, Director of Appellate Practices and Labor Relations, Department of Personnel, CN 312, Trenton, New Jersey 08625.

Summary of Public Comments and Agency Responses:

COMMENT: Natalie P. Havran, Director, Division of Human Resources, Department of Transportation, suggested that the reference to "salary level" in N.J.A.C. 4A:3-2.5 is incorrect, since Senior Executive Service (SES) positions are considered M98, namely, no range.

RESPONSE: While SES positions are designated M98, specific salary levels have been set in past years through salary regulations. In order to allow for future compensation programs specifically for SES, the terminology used in this rule will be retained.

COMMENT: Barbara Maccarillo, a State employee, objected to the proposed amendment to N.J.A.C. 4A:3-2.9, concerning rights of SES employees in the event of a reduction in force. She argued that the original intent of the SES was not to provide job security. Rather, she contended that SES positions should have been offered to those willing to trade job security for increased responsibilities, compensation and

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benefits. She maintained that codifying the practice of allowing SES members to return to their prior titles would worsen the situation wherein SES had not fulfilled its original purpose.

RESPONSE: The Board believes that the proposed amendment to N.J.A.C. 4A:3-2.9, which would codify existing practice, is consistent with the purpose of the SES. As set forth in the statute, N.J.S.A. 11A:3-3, SES members do not have the same job security as career service employees with respect to their SES position. However, those who were appointed to the SES from the career service have substantial rights with regard to return to the career service. The Board believes such rights should be applicable when a reduction in force takes place.

COMMENT: Sherryl Gordon, Executive Director, Council 1, American Federation of State, County and Municipal Employees (AFSCME), suggested that N.J.A.C. 4A:3-3.3(a)4, which provides for notice to appointing authorities and other affected persons of changes in classification plans, should also provide for notice to bargaining unit representatives.

RESPONSE: Changes in the classification plan are reflected in Salary Administration Memoranda (SAM's). There is no need to change the rule, since SAM's are curently distributed to the major State employee negotiations representatives, including AFSCME.

COMMENT: Ms. Gordon commented that N.J.A.C. 4A:3-3.6(b), concerning new titles, should require that appointing authorities notify bargaining unit representatives of requests for new titles or title series.

RESPONSE: The Board agrees with this comment. However, the obligation to provide notice to negotiations representatives of requests for new titles or title series is provided elsewhere, namely, the new subsection (f) in N.J.A.C. 4A:3-3.3.

COMMENT: Ms. Gordon commented that N.J.A.C. 4A:3-3.6 should be amended to place a limit on the number of Tentative Titles within an agency or department.

RESPONSE: Since the designation "Tentative Title" is used in conjunction with requests for new titles, this suggestion would be tantamount to placing a limit on the number of new titles each agency can request. Such a numerical limit would be impractical and inappropriate.

COMMENT: Ms. Havran commented that N.J.A.C. 4A:3-3.9(b) should be amended by including the Senior Executive Service (SES) as a category to which classification appeal procedures are applicable.

RESPONSE: Unlike the career and unclassified services, there are no specific titles within the SES. Rather, SES members are assigned to particular positions, with duties and responsibilities individually formulated with their managers. There would be no basis for an SES member to claim misclassification, and thus no reason to make formal classification appeal procedures applicable to the SES.

COMMENT: Jon Wineland, Staff Representative, Communications Workers of America (CWA) Local 1033, and Amy J. Bahruth, Staff Representative, CWA Local 1031, argued that N.J.A.C. 4A:3-3.9(c) should be amended to address the situation where a supervisor would not sign a classification questionnaire. They asserted that a supervisor's unwillingness or unavailability to sign should not hold up the classification appeal process. Mr. Wineland suggested that the rules be amended to provide that the supervisor's signature is not necessary or, in the alternative, allowing five days to obtain the supervisor's signature. He further suggested a similar amendment in subsection (d), concerning local service.

RESPONSE: While supervisor verification is ordinarily required on a classification questionnaire, the Board agrees that a classification appeal should not be delayed indefinitely in those instances when a supervisor is unavailable or unwilling to sign the questionnaire. Therefore, language is being added to subsections (c) and (d) to provide that a classification questionnaire may be forwarded to the Department of Personnel if the supervisor has not signed after five working days. Further, since classification questionnaires are needed in local service appeals only if requested by the Department of Personnel, language is being added to subsection (d) to reflect this practice.

COMMENT: Ms. Bahruth argued that there was no mechanism included in N.J.A.C. 4A:3-3.9(c)1 to ensure that the agency representative forwards the appeal to the Department of Personnel within 10 days. She suggested that a penalty be imposed on an appointing authority that does not comply with this requirement. Further, she suggested that the appellant be notified by the Department of Personnel when the appeal is received.

RESPONSE: The current practice of the Office of Personnel Management is to acknowledge classification appeals immediately upon receipt. Thus, when an appellant has not received such an acknowledgement or notice from the agency representative that additional information is required within the time frame specified in the rule, the appellant can initiate appropriate follow-up action. Therefore, the Board does not believe that additional changes in the rule are required at this time.

COMMENT: In N.J.A.C. 4A:3-4.6(b), Ms. Havran suggested that Family Leave be added to the types of leave which would not affect the anniversary date.

RESPONSE: The suggested amendment would be inconsistent with the rule governing Family Leave, N.J.A.C. 4A:6-1.21(i), which provides that, except for layoff purposes, Family Leave is to be treated the same as other leaves without pay.

COMMENT: Ms. Havran suggested that examples would be helpful in N.J.A.C. 4A:3-4.7, concerning types of pay adjustments.

RESPONSE: While examples are generally helpful, in this particular rule there are so many different transactions involved that a specific example may be confusing. Essentially, N.J.A.C. 4A:3-4.7 is simply a guide to application of the next four rule sections.

COMMENT: In N.J.A.C. 4A:3-4.10, Mr. Wineland argued that demotions under subsection (b), which involve loss of qualifications for a job title, should be treated the same as non-fault demotions, rather than disciplinary demotions, since these situations are not always the employee's fault. Ms. Havran suggested that the cross-reference in this subsection to "(a) above" (referring to disciplinary demotions) was in error. Rather, she said the cross-reference should be to "(c) below" (referring to non-disciplinary demotions).

RESPONSE: The cross-reference to "(a) above" is correct and reflects the intent that demotions due to such matters as suspension of a drivers' license are more similar to disciplinary demotions than they are to other non-fault types of demotions. However, there are situations where employees who lose qualifications for a job agree to a voluntary demotion on a temporary basis. Under current practice, these employees would be entitled to pay adjustment under the formula in subsection (c). To clarify this distinction, the word "involuntarily" will be added to subsection (b).

COMMENT: Dennis Spundarelli, Director of Human Resource Services, Department of Health, argued that N.J.A.C. 4A:3-4.10(c) is inequitable with regard to treatment of employees who are demoted to step eight of a range. Unlike other employees, they do not retain their anniversary date, but rather must wait 39 pay periods until advancement to the next step. As a result, he stated, some affected employees must wait more than two years for an increment. Employees who are demoted to step eight, he urged, should get credit for time spent in the previous step.

RESPONSE: The Board recognizes that the particular situation of employees demoted to step eight should be addressed. However, the amendment suggested by the commenter would be a substantive change requiring additional public notice and comment. Therefore, an amendment to address this situation will be proposed shortly.

COMMENT: Rose Wales and Margarete Belgrode, members of CWA Local 1039, commented that the practice of "red circling," as set forth in N.J.A.C. 4A:3-4.11 and 4.12, unfairly benefits politically-appointed unclassified employees. Ms. Wales further argued that career service employees who are demoted due to a reduction in force should be red circled instead of losing pay.

RESPONSE: Red circling is a long standing practice which has been applied to situations where the salary range of a title is reevaluated downward (N.J.A.C. 4A:3-4.11) or, more commonly, where a title is moved from a no-range status to a salary range (N.J.A.C. 4A:3-4.12). The rule is applicable to career service as well as unclassified employees, and ensures that individual employees are not adversely affected by an action that is intended to change the method of compensation for all employees serving in a title. In a reduction in force, however, some loss of pay is anticipated, since the reason for the action is economy.

COMMENT: Ms. Havran argued that N.J.A.C. 4A:3-5.10, concerning overtime appeals in State service, should be changed to be consistent with new procedures issued after the consolidation of personnel functions.

RESPONSE: The consolidation of personnel functions, as set forth in Executive Order No. 70(1992), did not affect the procedures for these appeals. Therefore, no changes in this section are necessary.

COMMENT: Ms. Havran commented that the chart in Appendix A should be modified to reflect the fact that NL and NL4 employees are no longer eligible for compensatory time off (CTO) if they are at or above Range 32.

RESPONSE: Appropriate notes will be added to the chart.

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Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 4A:3.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

4A:3-2.9 Separation from the SES: State service

(a)-(c) (No change.)

(d) If the position to which an SES member is appointed is vacated or abolished due to a reduction in force, and the SES member has career status, the SES member shall have lateral, demotional and special reemployment rights based upon the permanent title held immediately prior to SES appointment.

4A:3-3.3 Administration of classification plans

(a)-(d) (No change.)

(e) In State service, each department and autonomous agency shall designate an individual as the agency representative, to serve as its liaison with the Department of Personnel on all classification and compensation matters.

(f) In State service, the agency representative shall provide notice to affected and potentially affected negotiations representatives upon submission of the following to the Department of Personnel. The Department of Personnel shall verify that proper notice has been given of each of the following:

1. Reorganizations;
2. Job content reevaluation requests;
3. Requests for new titles or title series;
4. Job specification modification requests;
5. Employee relations group changes; and
6. Establishment, modification or termination of flexitime programs, alternate workweek programs and adjusted hours of operation.

4A:3-3.5 Reclassification of positions

(a) (No change.)

(b) An appointing authority may request a classification review by the Department of Personnel in a manner and form as determined by the Commissioner. Such review may be initiated by the Department of Personnel. An employee or union representative may request a classification review in accordance with N.J.A.C. 4A:3-3.9.

(c) No reclassification of any position shall become effective until notice is given affected permanent employees and approval is given by the Commissioner.

1. Within 30 days of receipt of the reclassification determination, unless extended by the Commissioner in a particular case for good cause, the appointing authority shall either effect the required change in the classification of an employee's position; assign duties and responsibilities commensurate with the employee's current title; or reassign the employee to the duties and responsibilities to which the employee has permanent rights. Any change in the classification of a permanent employee's position, whether promotional, demotional or lateral, shall be effected in accordance with all applicable rules.

2. Should an employee in the career or unclassified service in State or local service, or an appointing authority in local service, disagree with reclassification, an appeal may be filed in accordance with N.J.A.C. 4A:3-3.9.

4A:3-3.6 New titles

(a) The Department of Personnel may determine that a new title or title series is necessary, when it is found that a new set of functions is assigned to the position(s) being reviewed and these new functions are not appropriately described by an existing title or title series.

(b) Requests for new titles or title series must be submitted in writing by the appointing authority to the Department of Personnel on a designated form. In State service, such requests shall be submitted by the agency representative. The request must include:

1.-3. (No change.)

(c) If the Department of Personnel determines that there is a need for a new title or title series, a new job specification will be prepared and in State service the title will be evaluated for compensation purposes.

(d) Pending approval by the Commissioner of a new title or title series, the designation "Tentative Title" may be used for affected positions. See N.J.A.C. 4A:3-4.15 for compensation procedures in State service.

(e) In State service, appeals from a salary evaluation of a new title will be processed in accordance with N.J.A.C. 4A:3-4.3.

(f) The effective date of the creation of a new title by the Commissioner will be:

1. In State service:

i. The beginning of the pay period immediately after 14 days from the date the Department of Personnel receives the new title request and all requested information;

ii. The date of appointment to the Tentative Title; or

iii. An appropriate date as established by the Commissioner when a classification review has been initiated by the Department of Personnel; or

2. In local service, an appropriate date as established by the Commissioner.

4A:3-3.7 Trainee titles

(a)-(c) (No change.)

(d) Advancement to the lowest title in the related title series, referred to in this section as the primary title, shall take place only upon successful completion of the training period. The length of the training period shall be designated in the specification for the particular trainee title. The designated length shall not be longer than 12 months, unless otherwise provided by law. The training period must be continuous, except if interrupted by leave or layoff from the trainee title, and may include provisional service in the trainee or higher related title.

(e)-(f) (No change.)

(g) The advancement of the successful, permanent trainee to the appropriate primary title shall be accomplished without the usual promotional examination process, but rather by reclassifying the trainee position to an appropriate primary title and by concurrent regular appointment of the trainee to the position.

1. To effect advancement, the appointing authority must certify the trainee's successful completion of the training period, and, for those primary titles requiring extra training courses or the attainment of a proficiency standard over the trainee title requirements, that the trainee has successfully completed such requirements. A trainee may only receive advancement to one of the appropriate primary titles specified for that trainee title.

2.-3. (No change.)

4. Trainees advanced to a primary title shall be required to complete a working test period in the primary title. Trainees who fail to successfully complete their working test period in the primary title have no right to return to the trainee position.

4A:3-3.9 Appeal procedure

(a)-(b) (No change.)

(c) In State service, a classification appeal from an employee or union representative shall be submitted, in writing, to the agency representative. The appeal must identify the specific duties that do not conform to the specification for the title and, if the appellant proposes a different existing title for the position, an explanation of how that title more accurately describes the duties of the position than the current or proposed title. The appeal should also include a completed position classification questionnaire. ***If the appellant's supervisor has not signed the questionnaire within five working days of receipt, the appellant may forward the questionnaire to the agency representative without the supervisor's signature but with a notation of the date of presentation to the supervisor.***

1. The agency representative shall review the appeal, provide an organization chart and ensure that the information set forth in (c) above has been included. Within 10 days of receipt of the appeal, the agency representative shall either notify the appellant that specific additional information is required, or shall forward the appeal to the Department of Personnel and so notify the appellant, and may indicate a recommended approval or rejection of the appeal for specified reasons. If additional information is required, the agency representative shall forward the appeal to the Department of

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Personnel within 10 days of receipt of the appellant's response to the request for additional information.

2. A representative of the Department of Personnel shall review the appeal, request additional information if needed, order a desk audit where warranted, and issue a written decision. The decision letter shall be issued within 60 days of receipt of the appeal and all requested information and shall include a summary of the duties of the position, findings of fact, conclusions, a notice to an employee or authorized employee representative of appeal rights to the Commissioner and a determination that:

i. The position is properly classified;

ii. The position is properly classified, but that out-of-title duties are being performed, in which case the representative shall order, in writing, the immediate removal of inappropriate duties within a specified period of time; or

iii. The position should be reclassified, in which case, normal reclassification procedures shall be initiated immediately.

(d) In local service an appeal from an employee, union representative, or appointing authority shall be submitted, in writing, to the appropriate regional office of the Department of Personnel. The appeal must identify the specific duties that do not conform to the specification for the title and, if the appellant proposes a different title for the position, an explanation of how that existing title more accurately describes the duties of the position than the current or proposed title. *[The]* ***If requested by the Department of Personnel, the*** appeal should also include a completed position classification questionnaire and an organization chart. ***If the appellant's supervisor has not signed the questionnaire within five working days of receipt, the appellant may forward the questionnaire to the Department of Personnel without the supervisor's signature but with a notation of the date of presentation to the supervisor.***

1. A representative of the Department of Personnel shall review the appeal, request additional information if needed, order a desk audit where warranted, and determine that:

i.-iii. (No change.)

2. (No change.)

(e) Appeals to the Commissioner may be made by an employee, authorized employee representative or local appointing authority and shall be submitted in writing, within 20 days of receipt of the decision letter and must include copies of all materials submitted and the determination received from the lower level, state which portions of the determination are being disputed and the basis for appeal. Information and/or argument which was not presented at the prior level of appeal shall not be considered. When new information and/or argument is presented, the appeal may be remanded to the prior level.

1.-2. (No change.)

(f)-(h) (No change.)

4A:3-4.3 Job reevaluation requests and appeals: State service

(a) Appointing authorities may request a reevaluation by the Department of Personnel of a job title to determine its proper class code. The request, which shall be submitted through the agency representative, must include a brief rationale for the request, an organization chart, and the requested new salary level. The Department of Personnel may require additional information to be submitted in a manner and form as determined by the Commissioner.

(b) An appeal by an employee or authorized employee representative for a reevaluation shall be submitted, in writing, to the agency representative. The appeal must identify and explain the areas of substantive change in job content or other change in job evaluation factors through written narrative and a revised job specification, which shall be marked to indicate changes, and include evidence that the change in job content affects all employees in the title. The Department of Personnel may require additional information to be submitted in a manner and form as determined by the Commissioner.

1. The agency representative shall review the appeal and ensure that the information set forth in (b) above has been included. Within 10 days of receipt of the appeal, the appointing authority representative shall either notify the appellant that specific additional information is required, or shall forward the appeal to the Department of Personnel and so notify the appellant, and may indicate a recommended approval or rejection of the appeal for specified reasons. If additional information is required, the agency representative shall forward the appeal to the Department of Personnel within 10 days of receipt of the appellant's response to the request for additional information.

(c) A representative of the Department of Personnel shall review the request or appeal and render a written decision. A written decision on evaluation appeals shall be rendered within 60 days of receipt of all required information. The decision letter shall include a notice of appeal rights to the Commissioner in the case of an appeal by an employee or authorized employee representative.

(d) Any affected employee or authorized employee representative may appeal the determination to the Commissioner within 20 days of its receipt. The appeal shall contain all information which was presented to the prior level, a statement identifying the specific portions of the prior level determination being contested, and the basis for appeal. The appellant shall provide copies to all parties.

Recodify existing (f) and (g) as (e) and (f) (No change in text.)

(g) If a title is approved for reevaluation, the effective date of the reevaluation shall be the first full pay period following the receipt by the Department of Personnel of a fully documented request for reevaluation under (a) above or a fully documented appeal under (b) above.

4A:3-4.4 Salary rates for initial appointments: State service

(a) (No change.)

(b) When the employee has separated from another State appointing authority, a State college, Rutgers, the State University, the New Jersey Institute of Technology, or the University of Medicine and Dentistry of New Jersey, and has been hired without an interruption in service, the employee may be placed up to and including that step of the salary range that the employee would receive if the employee had been continuously employed in the new agency.

(c) (No change.)

4A:3-4.5 Anniversary dates: State service

(a) An anniversary date is the biweekly pay period in which an employee is eligible, if warranted by performance and place in the salary range, for a salary increase.

1. An employee's anniversary date shall be assigned upon initial appointment to the first pay period following the completion of 26 full pay periods after appointment. In years which contain 27 pay periods, anniversary dates shall be determined in accordance with a schedule issued by the Department of Personnel.

EXAMPLE: An employee is appointed to a position on Monday, August 16, 1993. The first full pay period following the date of appointment is pay period 18, which begins on August 21, 1993. The employee's anniversary date is pay period 18 in calendar year 1994, expressed as 18/94.

2.-3. (No change.)

(b)-(c) (No change.)

4A:3-4.6 Anniversary date change when employee is in non-pay status: State service

(a)-(b) (No change.)

(c) When an employee returns from one full pay period or more in non-pay status, or when an employee accumulates 10 or more working days in non-pay status on an intermittent basis, the appointing authority shall notify the Department of Personnel and the employee in writing that the anniversary date is to be changed. If an alternate worksheet program has been established, consideration of the adjusted hours per day must be made when counting the number of work days in non-pay status.

(d) Intermittent days without pay which total less than 10 shall not be carried forward to the next calendar year.

4A:3-4.8 Lateral pay adjustments: State service

(a) (No change.)

(b) Employees affected by a lateral pay adjustment shall have their pay adjusted to the same step in the salary range of the new title as that step at which they were paid in the salary range of the former title. The employee's anniversary date shall not be changed.

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EXAMPLE: An employee currently on step four, salary range A10, in a 35-hour workweek title (class code 11), is appointed to a 40-hour workweek title in class code 11. The new salary range will be A12, and the employee will be placed on step four.

(c) When a workweek change occurs for an employee whose salary is between steps of the range, the following calculation shall be made to accommodate the workweek adjustment. Divide the amount of extra salary by the amount of the increment of the employee's current salary range. This will provide a percentage of the current increment represented by the extra salary. Adjust the employee's salary to the new range at the same step. Calculate the amount of extra salary by applying the percentage arrived at above to the increment of the new range.

4A:3-4.9 Advancement pay adjustments: State service

(a) Employees who are appointed to a title with a higher class code shall receive a salary increase equal to at least one increment in the salary range of the former title plus the amount necessary to place them on the next higher step in the new range. If the workweek changes, workweek adjustments will be made prior to the determination of anniversary date. If the workweek increases, workweek adjustments will be made prior to salary determination. (See (f) below). This subsection shall apply when the following conditions are met:

1. Employees are appointed from their permanent title to a title with a higher class code following or subject to a promotional examination;

2. Employees are serving in a title which is reevaluated to a higher class code; or

3. Employees are appointed to a title with a higher class code, when the conditions in (a)1 or 2 above are not applicable, provided the Department of Personnel finds the following criteria are met:

i. The employee has served continuously in the lower title for at least four months immediately preceeding the effective date of the advancement; and

ii. The service in the lower title provided significant preparation and training for service in the higher title.

(b) When an employee is advanced to a title with a salary schedule which is different (dollar value of ranges and steps do not coincide) from the employee's previous salary schedule, the steps described in (a) above are first performed in the previous schedule, and then the employee's salary is set at the lowest step in the new schedule and range that equals or exceeds that salary.

(c) When an employee has been at the maximum of his or her previous salary range for at least 39 pay periods, and the salary increases after workweek adjustment would be less than two increments in the employee's previous range, the employee shall receive an additional increment in the new range, providing the employee is not already at the maximum of the new range.

(d) Employees who do not meet the criteria set forth in (a) above shall be placed on a step in the salary range of the title with the higher class code that is the same or next higher than the salary paid in the title with the lower class code.

1. The adjustments described in (b) and (c) above shall be applied as appropriate.

(e) The anniversary date will be retained if the total salary increase after workweek adjustment is less than two increments in the employee's previous range. If the total salary increase after workweek adjustment is two increments or more, or the advancement results in step eight or nine, the anniversary date will be determined by the effective date of the action (frozen if step eight or nine).

(f) The workweek adjustment is computed by finding the workweek adjusted range, according to the following chart, and then placing the employee on the same step in the workweek adjusted range as the employee's step in the former range.

		WORKWEEK OF EMPLOYEE'S NEW TITLE		
		35 OR 3E	NL OR NE	40, 4E OR N4
Workweek of Employee's Former Title	35 OR 3E	NO CHANGE	+1 SALARY RANGE	+2 SALARY RANGES
	NL or NE	−1 SALARY RANGE	NO CHANGE	+1 SALARY RANGE
	40, 4E OR N4	−2 SALARY RANGES	−1 SALARY RANGE	NO CHANGE

EXAMPLE: An employee on step four in salary range A10 in a 35-hour week title is appointed to a 40-hour week title. Adjusting salary range A10 (35 hours) to the 40-hour week (+2 salary ranges) will result in a range A12, step four.

(g) When an employee's work year changes, a work year adjustment shall first be performed before making any other adjustments under this section. The work year adjustment is computed by placing the employee in the same step three ranges up, when work year is increased from 10 to 12 months, or three ranges down, when work year is decreased from 12 to 10 months.

EXAMPLE: An employee on step four, range A10 in a 10 month title, is promoted to a 12 month title with salary range A15. There is no change in workweek. The work year adjustment would bring the employee to step four, range A13. Then, salary is calculated based on (a) above.

4A:3-4.10 Demotional pay adjustments: State service

(a) The salary of an employee who receives a disciplinary demotion shall be adjusted by reducing the employee's salary one increment in the higher range. Then, the employee's salary in the lower range will be set at the step that is equal to or next lower than such reduced salary.

1. The adjustment in (a) above shall be made after adjustment for workweek. See N.J.A.C. 4A:3-4.9(f).

i. When a workweek change occurs for an employee whose salary is between steps of the range, the following calculation shall be made to accommodate the workweek adjustment: Divide the amount of extra salary by the amount of the increment of the employee's current salary range. This will provide a percentage of the current increment represented by the extra salary. Adjust the employee's salary to the workweek adjusted range at the same step. Calculate the amount of extra salary by applying the percentage arrived at above to the increment of the workweek adjusted range.

2. The anniversary date is retained, unless the action results in step eight or nine, in which case the anniversary date is based on the effective date of the action.

(b) When an appointing authority demotes an employee ***involuntarily*** in lieu of removal due to loss of qualifications for job title (for example, a Truck Driver whose license is suspended is demoted to a Building Maintenance Worker), salary and anniversary date shall be determined as provided in (a) above. If the employee is subsequently returned to the former title, he or she may be appointed up to and including the step held prior to the demotion.

(c) If the demotion is other than disciplinary or in lieu of removal under (b) above, the employee's salary shall be reduced one increment in the higher range. Then the employee's salary in the lower range will be set at the step that is equal to or next higher than such reduced salary.

1. The adjustment in (c) above is made after adjustment for workweek. See N.J.A.C. 4A:3-4.9(d).

2. The anniversary date is retained, unless the action results in step eight or nine, in which case the anniversary date is based on the effective date of the action.

3. This adjustment shall be applied only when the employee has served at least four months in the higher title and:

i. The employee has previously held the lower title;

ii. The employee is being demoted in lieu of layoff; or

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iii. The Department of Personnel finds that service in the higher title provided significant preparation and training for service in the lower title.

4. If the conditions in (c)3 above are not met, then salary and anniversary date shall be determined by reconstructing the employee's salary as if the employee had remained in or been appointed to the lower title on the date he or she was appointed to the higher title. N.J.A.C. 4A:3-4.4 may be applied, but in no case shall an employee receive a higher salary than that calculated through the application of (c) above.

(d) For all non-disciplinary demotions except voluntary demotions and those provided in (b) above, an employee demoted to a title lower than the class code of his or her permanent title must be given 45 days' notice of demotion by the appointing authority.

(e) In no event shall this section be used to gain a salary advantage for an employee.

4A:3-4.11 Downward title reevaluation pay adjustments: State service

(a) When a title is reevaluated to a lower class code, or when a title is eliminated and incumbents are placed in a title having a lower class code, each employee in that title shall remain at his or her current base salary. The part of an employee's base salary that is above the nearest lower step in the lower range will be carried as extra salary until the employee's anniversary date, at which time the employee's salary shall be moved to the next higher step, if warranted by performance, in lieu of the normal performance increment. If the employee's base salary is above the maximum step, the employee will be red circled, that is, remain at that salary until the maximum step of the lower range is increased to a level at or above the employee's base salary, at which time the employee's salary shall be moved to that maximum step of the lower range.

1.-3. (No change.)

4A:3-4.12 Movement of employees from no-range or single rate titles to titles having salary ranges: State service

(a) When a title is changed from a no-range or single rate category to a range in the Compensation Plan, or when an employee moves from a no-range title to a title having a salary range, the salary shall be adjusted up to the step in the range that is the same or next higher than the salary of the no range or single rate title and the anniversary date assigned based on the pay period the employee would have been eligible for an increase in the no range or single rate title, providing the following two criteria are met:

1. The Department of Personnel finds that service in the no-range title provided the employee with significant experience and training for service in the range title; and

2. The employee has served in the former title for four months or more.

(b) (No change.)

(c) If the employee's base salary is above the maximum step, the employee will be red circled, that is, remain at that salary until the maximum step of the range is increased to a level at or above the employee's base salary, at which time the employee's salary shall be moved to that maximum step of the range.

(d) (No change in text.)

4A:3-4.13 Salaries of employees whose annual salaries are not on a step in their salary range: State service

Except as otherwise provided by the Commissioner, an employee whose base salary is not on a step in his or her salary range shall remain at his or her current base salary. That part of an employee's salary that is above the nearest lower step in the salary range will be carried as extra salary until the employee's anniversary date, at which time the employee's salary shall be moved to the next higher step, if warranted by performance, in lieu of the normal performance increment. If the employee's base salary is above the maximum step, the employee will be red circled, that is, remain at that salary until the maximum step of the range is increased to a level at or above the employee's base salary, at which time the employee's salary shall be moved to that maximum step of the range.

4A:3-4.17 Salaries and anniversary dates for employees appointed from a special reemployment list: State service

(a) The salary of an employee appointed from a special reemployment list shall be determined as follows:

1. When appointed to the same title held at the time of the reduction in force, the employee shall receive the same step of the salary range received on the date of the layoff or the salary determined in accordance with (a)2 below, whichever is the most beneficial to the employee.

2. When appointed to a different title from the one held at the time of the reduction in force, the employee shall receive the most beneficial to the employee of the following:

i. The same step and salary range that he or she would have received if appointed to the new title on the date of the reduction in force; or

ii. When the employee is currently serving in another title, the salary determined by adjustment to the new title:

(1) When appointed to a new title with the same class code, make a lateral pay adjustment, N.J.A.C. 4A:3-4.8;

(2) When appointed to a new title with a higher class code, make an advancement pay adjustment, N.J.A.C. 4A:3-4.9. If the employee has attained a higher salary in a lower title than the current value of the step he or she would have received in the new title on the date of the layoff, the salary shall be set at the step that is next higher than the salary in the lower title. The anniversary date will be set based on the effective date of the action; or

(3) When appointed to a new title with a lower class code, make a demotional pay adjustment, N.J.A.C. 4A:3-4.10.

(b) The anniversary date of an employee appointed from a special reemployment list shall be determined as follows:

1. When using (a)1 or (a)2i above to determine salary, reconstruct the employee's anniversary date to the date of the reduction in force, then calculate the additional number of pay periods needed to meet the requirements for a performance increment (except as provided in (a)2ii(2)). Assign the anniversary date which will include the additional number of pay periods of service needed to satisfy anniversary date requirements.

2. (No change.)

3. If at the time of the reduction in force the employee was at the maximum salary step for the title from which displaced, assign the anniversary date that reflects the length of time that the employee had been at the maximum step on the date of the reduction in force.

EXAMPLE: An employee is reappointed from a special reemployment list on April 3, 1993 (pay period 8/93) to the permanent title from which the employee was laid off on January 23, 1993 (pay period 3/93). At the time of the layoff the employee was receiving the ninth step of the salary range with an anniversary date of 1/93. When reappointed, the employee will receive an anniversary date of 6/93 to show that the employee had been at the maximum step of the salary range for two pay periods.

(c)-(d) (No change.)

(e) This section shall be applied to unclassified or provisional employees recalled after a reduction in force in accordance with a collective negotiations agreement.

4A:3-4.20 Retroactive pay: State service

Personnel actions having retroactive effective dates shall apply only to employees who remain on a State payroll on the date of the retroactive payment and employees who retire or die during the period of retroactive application.

4A:3-5.2 Definitions: State service

The following terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

...

"Pay period" means the period beginning 12:01 A.M. Saturday and ending midnight the second Friday following (Note: A schedule of pay periods is published annually by the New Jersey Department of the Treasury.).

...

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4A:3-5.7 Special circumstances: State service

(a)-(c) (No change.)

(d) Eligibility for overtime compensation for exceptional emergencies shall be as follows:

1. When an agency head declares an exceptional emergency involving a critical service disruption that poses a danger to health or safety, he or she may authorize:

i. Cash overtime compensation for non-limited employees in titles with established salary ranges below range 32 performing emergency related work. For these circumstances employees in non-limited titles shall be deemed to have a 40 hour workweek.

ii. Overtime compensation for work not covered by the job specification. See N.J.A.C. 4A:3-5.3(c)3.

2. An agency head shall file with the Commissioner two reports concerning an exceptional emergency as follows:

i.-ii. (No change.)

3. These provisions shall not apply to work performed beyond the regular work hours on emergency maintenance, construction, snow removal or other related work in situations which constitute unreasonable safety hazards to the public, employees, other persons or property of the State. The Commissioner shall establish emergency condition rates for these circumstances.

(e) (No change.)

4A:3-5.8 Holiday pay: State service

(a)-(b) (No change.)

(c) The following shall govern overtime compensation for full-time and part-time employees in fixed workweek titles who are employed in a seven day coverage operation:

1.-2. (No change.)

3. If a holiday occurs on a regular workday of an employee and the employee does not report for duty, he or she shall not be eligible for overtime compensation or an alternate day off for that holiday.

(d) A part-time or full-time employee in a fixed workweek title, in conjunction with his or her appointing authority, may agree to work on a holiday in exchange for a specified day of personal preference off. If the employee is required to work on the specified personal preference day, she or he shall be entitled to overtime compensation for all hours worked on the personal preference day as if that day were the holiday.

(e) (No change.)

4A:3-5.10 Appeal procedures: State service

(a) Appeals may be filed under this subchapter as follows:

1. Position designation appeals, in which the issue is the status of a particular position as exempt or covered under the Fair Labor Standards Act, 29 U.S.C. 201 et seq.; and/or

2. (No change.)

(b)-(d) (No change.)

APPENDIX A: OVERTIME ELIGIBILITY AND COMPENSATION CHART

ELIGIBILITY STATUS		COMPENSATION	
	Comp Plan	In excess of 35 but not more than 40 hours per workweek	In excess of 40 hours per workweek as prescribed by FLSA
35 (covered)	35	Cash compensation at one and one-half times the hourly proration of the base salary or compensatory time off (CTO) at one and one-half times the hours worked.	Cash compensation at one and one-half times the regular rate[1] or CTO at one and one-half times the hours worked providing the employee has not accrued more than 250 hours of CTO.[2]
35 (exempt)	3E	Cash compensation at one and one-half the hourly proration of the base salary or CTO at one and one-half times the hours worked.	Cash compenstion at one and one-half times the hourly proration of the base salary or CTO at one and one-half times the hours worked.
40 (covered)	40	Not applicable	Cash compensation at one and one-half times the regular rate[1] or CTO at one and one-half the hours worked providing the employee has not accrued more than 240 hours of CTO.[2]
40 (exempt)	4E	Not applicable	Cash compensation at one and one-half times the regular rate or CTO at one and one-half times the hours worked.
NL (covered)	NE	No cash compensation. CTO for unusual work time to a maximum of hour for hour (discretionary).*4*	Cash compensation at one and one-half times the regular rate[1] or CTO at one and one-half times the hours worked providing the employee has not accrued more than 240 hours of CTO.[2]
NL (exempt)	NL	No cash compensation. CTO for unusual work time to a maximum of hour for hour (discretionary).*4*	No cash compensation.[3] CTO for unusual work time to a maximum of hour for hour (discretionary).*5*
NL4 (exempt)	N4	Not applicable.	No cash compensation.[3] CTO for unusual work time to a maximum of hour for hour (discretionary).*5*

1. Regular rate is the hourly proration of the employee's annual base salary plus the fair market value of goods and facilities received as part of the wages. Employees who work at different pay rates in a single workweek shall have their hourly proration based on a weighted average of the different rates.
2. Note: Employees engaged in a public safety activity, an emergency response activity, or a seasonal activity may accrue not more than 480 hours of CTO.
3. Except as provided in N.J.A.C. 4A:3-5.7(d) (Exceptional Emergencies).

4. Except as provided in N.J.A.C. 4A:3-5.3(d)2.

5. Except as provided in N.J.A.C. 4A:3-5.6(b)2.

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COMMUNITY AFFAIRS

(a)

OFFICE OF THE COMMISSIONER
Department Records
Readoption with Amendments: N.J.A.C. 5:3

Proposed: June 7, 1993 at 25 N.J.R. 2157(a).
Adopted: July 22, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.
Filed: July 30, 1993 as R.1993 d.419, **without change**.
Authority: N.J.S.A. 52:27D-3, 55:13B-7, 52:27D-201, 52:27D-203, 52:27D-124, 46:3B-5 and 52:27C-24.
Effective Date: July 30, 1993, Readoption;
September 7, 1993, Amendments.
Expiration Date: July 30, 1998.

Summary of Public Comments and Agency Responses:
A comment was received from Paul J. Carrafa, Vice President of Building Inspection Underwriters, Inc.

COMMENT: Designating "all records containing financial, organizational or other information pertaining to the business operations of any firm or company required to provide information to the Department in connection with any code enforcement program" as nonpublic records violates common law and the New Jersey "Right to Know" law (N.J.S.A. 47:1A-1 et seq.). Members of the public should not have to provide any justification in order to be allowed to review these documents. Public review is the only means to ensure that material submissions are complete and that there is uniform enforcement of State regulations.

RESPONSE: N.J.S.A. 47:1A-2 specifically allows an agency to determine, by rule, whether records are to be deemed public or not. If an agency determines that information submitted to it ought not to be subject to indiscriminate public inspection, it clearly has authority, under the "Right to Know" law, to declare that information to be "nonpublic," provided it does so by rule.

This rule specifically refers to P.L. 1963 c.73, which is the session law designation of the "Right to Know" law, and does not purport to affect common law rights of inspection of public documents. Even if a document is "nonpublic" for purposes of the "Right to Know" law, it may still be subject to inspection by a person having the requisite interest and standing. (See, for example, *Beck v. Bluestein,* 194 *N.J. Super* 247 (App. Div. 1984).)

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 5:3.

Full text of the adopted amendments follows:

CHAPTER 3
DEPARTMENT RECORDS

SUBCHAPTER 1. GENERAL PROVISIONS

5:3-1.1 Nonpublic records

(a) Throughout the entire Department of Community Affairs, the following shall not be deemed to be public records subject to inspection and examination and available for copying pursuant to P.L. 1963, c.73:

1. (No change.)

2. All personnel records, job applications and statements filed pursuant to the Department of Community Affairs' Code of Ethics; and

3. Any Social Security number submitted to the Department by any person. If any otherwise public record contains a Social Security number, the Social Security number shall be concealed or removed from the document before it is made available for public inspection, examination or copying.

(b) (No change.)

(c) The following records of the Division of Housing and Development are also deemed to be nonpublic records:

1.-4. (No change.)

5. All records containing financial, organizational or other information pertaining to the business operations of any firm or company required to provide information to the Department in connection with any code enforcement program.

5:3-1.2 Social Security numbers

(a) Except as otherwise provided by Federal law, no division, bureau or other unit within the Department of Community Affairs may require any person to submit his or her Social Security number as a condition for acceptance of an application for licensure, certification, registration or assistance.

(b) Units within the Department of Community Affairs responsible for the enforcement of the Rooming and Boarding House Act of 1979, the State Uniform Construction Code Act, the Uniform Fire Safety Act, the New Home Warranty and Builders' Registration Act and the Prevention of Homelessness Act may request voluntary submission of Social Security numbers for use in connection with criminal background checks or credit checks needed for purposes of licensure, certification, registration or assistance, as the case may be. No application shall be denied for failure to comply with any such request; provided, however, that a person who refuses to submit a Social Security number may be required to submit such other information as the Department may require in order to determine an applicant's eligibility for licensure, certification, registration or assistance, as the case may be.

(c) Any form used by any unit within the Department to request submission of a Social Security number shall include the following:

1. A statement as to whether provision of the Social security number is mandatory or voluntary;

2. A citation of the statute or rule (which, in the case of a request for voluntary submission, shall be this section, together with N.J.S.A. 55:13B-7, 52:27D-201, 52:27D-203, 52:27D-124, 46:3B-5 or 52:27C-24, whichever may be applicable) that authorizes the Department to require or request the Social Security number; and

3. A statement of the use or uses that the Department will make of the Social Security number.

(b)

DIVISION OF FIRE SAFETY
Fire Service Training and Certification
Adopted Amendments: N.J.A.C. 5:18C-4.2, 5.2, 5.3 and 5.4

Proposed: May 3, 1993 at 25 N.J.R. 1846(a).
Adopted: August 11, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.
Filed: August 16, 1993 as R.1993 d.440, **without change**.
Authority: N.J.S.A. 52:27D-25d, 52:27D-198 and 52:27D-219.
Effective Date: September 7, 1993.
Expiration Date: February 5, 1995.

Summary of Public Comments and Agency Responses:
Comments were received from Captain James C. Mueller of the Jersey City Fire Department; Chief John Fuhrman of the Bergenfield Fire Department; Chief William Ruggiano of the Lenola Volunteer Fire Company; Stephen J. Vreeland, a member of the New Jersey Fire Safety Commission; and John G. Riker of the Newark Fire Department and the Passaic County Fire Service Training Academy.

COMMENT: Firefighters should not be allowed to get Firefighter I certification solely on the basis of experience. A person who receives certification this way will not know the basics, including the proper use of air packs, when he goes on to the Firefighter II and Firefighter III levels. If the experience is in a volunteer department, there will not be sufficient work to allow adequate on-the-job training. There will be liability problems if firefighters who did not receive adequate training are killed in fires.

RESPONSE: Allowing firefighters to obtain Firefighter I certification based on having at least 18 months experience prior to July 1, 1994 is intended as a temporary measure to allow experienced firefighters to gain certification. There is wide acceptance within the New Jersey fire service of 18 months as a reasonable level of experience. Certification earned in this way may not be acceptable to all departments and fire academies, but they are entitled to establish whatever higher require-

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ments they may deem appropriate for employment and for enrollment in advanced courses. No training requirements of any fire department or fire academy will be affected by this rule.

COMMENT: The Department should establish mandatory training requirements.

RESPONSE: The Department does not have statutory authority to enforce such a requirement.

COMMENT: Persons seeking instructor certification should not be allowed to substitute experience for course work.

RESPONSE: The rules already allow substitution of experience. This proposal adds language adjusting the dates between which such experience may have been gotten.

COMMENT: There should be no change in the requirement that all level 2 instructors complete an educational methodologies course. Having taught 20 contact hours is not an adequate substitute.

RESPONSE: The provision allowing substitution of experience in teaching 20 contact hours is already in the rules. This amendment is limited to adjustment of dates.

Full text of the adoption follows:

5:18C-4.2 Firefighter I certification

(a) A certification for firefighter I shall be granted to an individual who is at least 18 years of age and has met any one of the following requirements:

1. Shall have been an active member of a fire department for a period of not less than 18 months prior to July 1, 1994. Proof of active membership in a fire department shall be verified by a letter from the chief of the department on fire department letterhead;

2. Shall have completed, prior to July 1, 1994, a course of instruction approved in accordance with N.J.A.C. 5:18C-2.3(g); or

3. Has met all of the following requirements:

i. Has successfully completed all instructional modules listed in N.J.A.C. 5:18C-4.3;

ii. Has taken and passed a written examination as established by N.J.A.C. 5:18C-4.4(a); and

iii. Has successfully passed a skills test as established by N.J.A.C. 5:18C-4.4(b).

5:18C-5.2 Instructor Level 1

(a)-(b) (No change.)

(c) The following standard applies to programs designed to satisfy the requirements for the course "Instruction Techniques: Instructor Level 1":

1.-2. (No change.)

3. The following certificates, courses, or experience will be accepted as substitutes for the course "Instruction Techniques: Instructor Level 1" until July 1, 1996:

i.-ii. (No change.)

iii. The course "Instructional Techniques for Company Officers" as developed by the National Fire Academy taken prior to July 1, 1994;

iv. (No change.)

v. Two years of experience as a fire service instructor with at least 10 contact hours of instruction between February 5, 1988 and July 1, 1994 may be substituted for the "Instruction Techniques: Instructor Level 1" course.

(d)-(e) (No change.)

(f) Applicants for the Instructor Level 1 certification shall demonstrate knowledge of the subject areas by successful completion of the Instructor Level 1 written examination administered through the Office of Training and Certification.

1. Three years of active firefighting experience prior to July 1, 1994 may be substituted for the written examination until July 1, 1996.

5:18C-5.3 Instructor Level 2

(a) (No change.)

(b) To obtain a certification as Instructor Level 2, an individual must meet the following requirements:

1. (No change.)

2. Possess a certification as Instructor Level 1 for at least two years.

i. Until July 1, 1996, two years of experience as a fire service instructor with at least 20 contact hours of instruction between February 5, 1988 and July 1, 1994, plus satisfactory completion of the safety course specified in N.J.A.C. 5:18C-5.2(d) may be substituted for the above.

3.-4. (No change.)

5. Satisfactorily pass the written test specified in (e) below.

i. Five years of active firefighting experience prior to July 1, 1994 may be substituted for the written examination until July 1, 1996.

(c) The following standard applies to programs designed to satisfy the requirements for the course "Instruction Techniques: Instructor Level 2."

1.-3. (No change.)

4. Until July 1, 1996, the following certificates or courses can be substituted for the course "Instruction Techniques: Instructor Level 2."

i.-ii. (No change.)

iii. The course "Educational Methodology" as developed by the National Fire Academy taken prior to July 1, 1994;

iv. Any other course taken prior to July 1, 1994 can be submitted by the candidate to the Office of Training and Certification for evaluation as an equivalent. The office will maintain a list of reviewed and approved substitute courses; or

v. Two years of experience as a fire service instructor with 20 contact hours of instruction between February 5, 1988 and July 1, 1994.

(d)-(e) (No change.)

5:18C-5.4 Special instructor certificates

(a) (No change.)

(b) The following relate to the live burn instructor certificate:

1. (No change.)

2. An individual seeking a live burn instructor certificate shall complete the following requirements:

i.-ii. (No change.)

iii. Successfully complete the live burn instructor written and skills examination administered through the Office of Training and Certification. The examination shall not be required for individuals meeting all other requirements of this section and applying for certification on or before July 1, 1996.

(c) The following apply to the SCBA/Smokehouse certificate:

1. An individual seeking a SCBA/Smokehouse certificate shall meet the following requirements:

i.-ii. (No change.)

iii. Successfully complete the SCBA/Smokehouse instructor written and skills examination administered through the Office of Training and Certification. The examination shall not be required for individuals meeting all other requirements of this section and applying for certification on or before July 1, 1996.

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code

Prior Approvals

Abandoned Wells

Adopted Amendments: N.J.A.C. 5:23-1.4, 2.16 and 2.17

Proposed: June 7, 1993 at 25 N.J.R. 2158(a).

Adopted: July 28, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.

Filed: July 30, 1993 as R.1993 d.420, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 52:27D-124.

Effective Date: September 7, 1993.

Expiration Date: February 3, 1998.

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Summary of Public Comments and Agency Responses:

Comments were received from Miss Calliope Alexander, Borough Sanitarian of the Kinnelon Board of Health.

COMMENT: Records concerning wells are kept by local health departments. Construction officials are allowed to expunge their files after five years, while it is the practice of health departments to retain well records indefinitely. This rule, if adopted, will therefore result in a loss of information concerning wells.

RESPONSE: This proposed rule in no way limits or detracts from the jurisdiction of health officers. Its sole purpose is to establish a procedure whereby construction officials, who may be called upon to issue permits for construction or demolition activities that may result in abandonment of wells, can provide information requested by the Bureau of Water Allocation. In no way is this rule intended to interfere, nor does it interfere, with the existing role of health officers or in any working relationship that they may have with the Bureau of Water Allocation. All that the Bureau of Water Allocation has asked for is information concerning possible abandonments, and the Department is sure that they will appreciate receiving it from health officers as well as from construction officials.

COMMENT: The likelihood of abandonment of a well when a structure is demolished is minimal, since having a well on the property will add to its value.

RESPONSE: The rule does not presume that a well will be abandoned when a structure is demolished. N.J.A.C. 5:23-2.17(a)1 applies only "in the event that there is a well on the property that has been abandoned, or that will be abandoned in conjunction with the proposed demolition." The commentor's statement to the contrary notwithstanding, the Bureau of Water Allocation is very much concerned about wells being abandoned when buildings are demolished, this being a particularly serious problem with some older industrial properties where there is a real potential for pollution of the aquifer.

COMMENT: Even when a building is connected to a public water supply, the well may be kept for gardening purposes if the owner obtains an irrigation well permit from the Department of Environmental Protection and Energy.

RESPONSE: N.J.A.C. 5:23-2.16(k) has been amended to make allowance for continued use of wells for irrigation purposes when connection is made to a public water supply. A certificate of occupancy or certificate of approval for connection to a public water supply may be issued if an irrigation well permit from the Bureau of Water Allocation is presented to the construction official.

Full text of the adoption follows (additions indicated in boldface with asterisks ***thus***).

5:23-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Prior approvals" means the necessary certifications or approvals issued or authorized by any Federal or State agency, or any political subdivision of the State, which are not inconsistent with this chapter and which are conditions precedent to the issuance of a construction permit or a certificate of occupancy or approval, as the case may be, which shall include, but not be limited to, the following:

1. Zoning;
2. Soil erosion and sediment control;
3. Highway curb cuts;
4. Water and sewer treatment works approvals;
5. Coastal areas facilities review;
6. Compliance of underground storage tank systems with N.J.A.C. 7:14B;

i. An approval granted by either the Department of Environmental Protection and Energy or the construction official by authority of N.J.A.C. 7:14B shall be deemed to be a prior approval;

7. Pinelands review; and
8. Compliance of abandoned wells with N.J.A.C. 7:9-9.

i. Compliance with N.J.A.C. 7:9-9.1 shall be evidenced by a certification issued by a well driller licensed by the Department of Environmental Protection and Energy.

. . .

5:23-2.16 Construction permits—procedure

(a)-(j) (No change.)

(k) Notice regarding wells: In the event that an application is made for a certificate of occupancy or certificate of approval for connection to a public water supply for a property either currently or previously served by a well not certified by a licensed well driller as having been sealed in accordance with N.J.A.C. 7:9-9, the construction official shall not issue the certificate until the certification by the licensed well driller ***or an irrigation well permit from the Bureau of Water Allocation*** has been submitted. In the event that no such certification ***or permit*** is submitted to the construction official within 15 days following either application for the certificate of occupany or approval or connection to the public water supply, whichever comes first, the construction official shall give notice of the absence of a certification ***or permit*** to the Bureau of Water Allocation, New Jersey Department of Environmental Protection and Energy, CN 029, Trenton, NJ 08625.

1. Notice shall also be given by the construction official to the Bureau of Water Allocation in the event of any demolition activity found to have been undertaken without a permit at a building or premises currently or previously served by a well and in any other case in which no permit application for demolition has been made but the construction official becomes aware that a well has been *,* or is about to be*,* abandoned without having been sealed by a licensed well driller.

5:23-2.17 Demolition or removal of structures

(a) Service connections: Before a structure can be demolished or removed, the owner or agent shall notify all utilities having service connections within the structure, such as water, electric, gas, sewer and other connections. A permit to demolish or remove a structure shall not be issued until releases are obtained from all utilities that provided service to the property, stating that their respective service connections and appurtenant equipment, such as meters and regulators, have been removed or sealed or plugged in a safe manner.

1. In the event that there is a well on the property that has been abandoned, or that will be abandoned in conjunction with the proposed demolition, a permit to demolish or remove a structure on that property shall not be issued until a certification has been obtained from a well driller licensed by the Department of Environmental Protection and Energy indicating that the well has been sealed in accordance with N.J.A.C. 7:9-9. If such certification is not presented within 15 days of the application for the permit, the construction official shall give notice of the absence of such certification to the Bureau of Water Allocation.

(b)-(d) (No change.)

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Certificate of Occupancy Requirements
Adopted Amendment: N.J.A.C. 5:23-2.23

Proposed: June 7, 1993 at 25 N.J.R. 2161(a).

Adopted: July 22, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.

Filed: July 30, 1993 as R.1993 d.421, **without change**.

Authority: N.J.S.A. 52:27D-124.

Effective Date: September 7, 1993.

Expiration Date: February 3, 1998.

Summary of Public Comment and Agency Response:

No comments received.

Full text of the adoption follows:

5:23-2.23 Certificate of Occupancy requirements

(a)-(e) (No change.)

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(f) Application: A written application for a certificate of occupancy shall be filed with the enforcing agency by the owner or his agent. The application shall include the following:

1.-5. (No change.)

6. A set of "as built" or amended drawings if the building or structure deviates from the approved plans filed with the construction permit application; and

7. A test and balance report for mechanically ventilated Class I and II buildings of Use Groups B and E submitted by a licensed professional engineer or by a test and balance professional certified by the Associated Air Balance Council or the National Environmental Balancing Bureau. The signed report shall include:

i. Minimum quantity of outdoor air required by code;

ii. Minimum quantity of outdoor air specified in the design;

iii. Actual measured outdoor cubic feet/minute (CFM) or a derived quantity, if actual measurement is not possible; and

iv. Actual measured total CFM.

(g)-(l) (No change.)

(a)

DIVISION OF COMMUNITY RESOURCES

Office of Recreation Rules

Handicapped Persons Recreational Opportunities

Readopted with Amendment: N.J.A.C. 5:51

Proposed: June 21, 1993 at 25 N.J.R. 2633(a).

Adopted: August 4, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.

Filed: August 11, 1993 as R.1993 d.436, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 52:27D-173.

Effective Date: August 11, 1993, Readoption;
September 7, 1993, Amendments.

Expiration Date: August 11, 1998.

Summary of Public Comments and Agency Responses:

A comment was received from Fred Patterson, President of The Arc of New Jersey.

COMMENT: The Arc of New Jersey (formerly the Association for Retarded Citizens of New Jersey), the State's largest nonprofit organization for people with mental retardation, supports the amendments that have been made to the rules, particularly those that do away with "archaic terminology which stigmatizes people with development disabilities" and replace it with "Person-First" language that is more respectful. However, there is one place where this has not been done, namely the definition of "persons with disabilities." "Persons who are mentally retarded," for example, should be changed to "persons who have mental retardation."

RESPONSE: The definition has been changed as recommended.

Full text of the adoption follows (additions indicated in boldface with asterisks ***thus***; deletions indicated in brackets with asterisks *[thus]*).

5:51-1.1 Introduction and general provisions

(a) The Handicapped Persons' Recreational Opportunities Act of 1978 was enacted to encourage and support the promotion, planning, development, implementation and maintenance of comprehensive recreation and leisure services to persons with disabilities by municipal and county governments as a public policy of the State of New Jersey.

(b) The Handicapped Persons' Recreational Opportunities Act of 1978 is administered by the Department of Community Affairs through the Office of Recreation. All correspondence and inquiries should be addressed to the Office of Recreation, Department of Community Affairs, 101 South Broad Street, CN 814, Trenton, New Jersey 08625.

(c) The general purposes of the Handicapped Persons' Recreational Opportunities Act are:

1. To reinforce the status of persons with disabilities as members of the total society;

2. To promote the least restrictive environment in providing recreation and leisure services for persons with disabilities; and

3. To assist local governments in the commencement or expansion of recreation and leisure services for persons with disabilities.

5:51-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

. . .

"Comprehensive Recreation Services" means a continuous integrated or specialized recreation and leisure service program for persons with disabilities that promotes and provides the least restrictive environment for a person with disabilities as an integral and on-going aspect of a local government's recreation and leisure service program.

. . .

"Non-Profit Agency" means a private non-profit agency serving persons with disabilities.

"Non-Profit Agency Resolution" means a formal written resolution signed by the chairman of the board of directors of a private non-profit agency certifying the non-profit agency's intent to enter into an agreement with a local government to service the recreation and leisure needs of persons with disabilities.

. . .

"Persons with disabilities" means persons who *[are mentally retarded, visually disabled, auditorily disabled]* ***have mental retardation, visual disability, auditory disability***, communication *[disabled, neurologically or perceptually impaired, orthopedically disabled, chronically ill, emotionally disturbed, socially maladjusted, multiply disabled or developmentally disabled]* ***disability, neurological or perceptual impairment, orthopedic disability, chronic illness, emotional disturbance, social maladjustment, multiple disability or developmental disability***.

"Special Event" means a relatively short-term special activity or program that fulfills particular and specific objectives for those persons with disabilities participating.

5:51-1.3 Eligible applicants

(a) (No change.)

(b) The following activities for persons with disabilities shall be accepted as eligible activities for participation in the program.

1.-2. (No change.)

(c) (No change.)

5:51-1.4 Application procedure

(a)-(d) (No change.)

(e) A non-profit agency serving persons with disabilities may become eligible to participate in the program by entering into a formal agreement with a local government. The name and address of the non-profit agency shall be submitted as an attachment to the application.

(f) (No change.)

(g) The proposed third party agreement between the local government and the non-profit agency serving persons with disabilities must be completed in compliance with the Local Public Contract Law, as determined by the Department.

(h) (No change.)

5:51-1.5 Application processing and review procedure

(a)-(c) (No change.)

(d) Prior to any payment being made by the Department, a local government shall submit one of the following documents:

1.-2. (No change.)

3. A letter from the Chief Financial Officer or the Chief Executive Officer stating that, upon adoption of its budget, the local government shall comply with N.J.S.A. 52:27D-170 et seq.;

4. A certificate guaranteeing that the local government will include in its budget an appropriation for the necessary matching funds and, upon adoption of the budget, will comply with N.J.S.A. 52:27D-170 et seq.; or

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5. A copy of a resolution indicating that the match requirement of N.J.A.C. 5:51-1.3(c)3 shall be met.

(a)

DIVISION ON AGING

Congregate Housing Services Program
Service Subsidy Formula
Adopted Amendment: N.J.A.C. 5:70-6.3

Proposed: June 21, 1993 at 25 N.J.R. 2634(a).
Adopted: August 6, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.
Filed: August 12, 1993 as R.1993 d.437, **without change**.
Authority: N.J.S.A. 52:27D-188.
Effective Date: September 7, 1993.
Expiration Date: April 22, 1997.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

5:70-6.3 Income, program costs, and service subsidy formula
(a)-(d) (No change.)
(e) Service subsidies for eligible program participants shall be provided in accordance with the following formula, as adjusted pursuant to (f) below:
1. (No change.)
2. (No change in text.)
(f) The categories of disposable income set forth in (e) above for use in determining percentage levels of program service subsidies shall be adjusted annually on January 1 for all years after 1993. The adjustment shall be made on the basis of the percentage increase in Social Security benefits given to Social Security recipients pursuant to 42 U.S.C.A. 415 for the immediately preceding calendar year. The limits defining each income category set forth above shall be determined annually by multiplying the income limits for the previous year by such percentage increase. The Division on Aging shall ensure that a public notice of the upper and lower limits of each category of disposable income for the coming year, together with the program service subsidy for each such category, is published in the New Jersey Register prior to the end of each calendar year and that appropriate notification of each such annual adjustment is otherwise properly given to interested parties.

ENVRONMENTAL PROTECTION AND ENERGY

(b)

AIR QUALITY REGULATION PROGRAM

Air Pollution Control
Permits, Certificates, Hearings and Confidentiality
Adopted Amendments: N.J.A.C. 7:27-8.1 and 8.3
Adopted New Rule: N.J.A.C. 7:27-8.27

Proposed: December 7, 1992 at 24 N.J.R. 4323(a).
Adopted: August 5, 1993 by Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.
Filed: August 9, 1993 as R.1993 d.428, **with substantive and technical changes** not requiring additional public Notice and Comment (see N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 26:2C-1 and 13:1D-35 et seq.
DEPE Docket Number: 50-92-10.
Effective Date: September 7, 1993.
Operative Date: October 4, 1993.
Expiration Date: Exempt.

Summary of Public Comments and Agency Responses:
On December 7, 1992, at 24 N.J.R. 4323(a), the New Jersey Department of Environmental Protection and Energy (the Department) proposed amendments and new rules at N.J.A.C. 7:27-8, entitled, "Permits, Certificates, Hearings and Confidentiality," hereinafter referred to as "subchapter 8," in order to improve the overall effectiveness of the preconstruction permit program and to encourage facility-wide permitting under the New Jersey Pollution Prevention Act (N.J.S.A. 13:1D-35 et seq.). The proposed amendments and new rules were intended to classify certain changes made to equipment or control apparatus as "amendments," rather than "alterations," if the applicant has a "facility-wide permit" as defined pursuant to the Pollution Prevention Act and meets other criteria in these rules. The amendment process involves reporting of changes to the Department after they have been made, while the alteration process involves preconstruction review and approval by the Department before the changes are made.

A public hearing was held on January 11, 1993, to provide interested parties the opportunity to present testimony on the proposed amendments and new rules. The comment period closed January 22, 1993. The Department received written testimony from five persons. One person presented both written and oral comments. One person presented only oral testimony at the public hearing. The commenters were as follows:
1. Barbara Klag, Schering-Plough Corporation
2. A.N. Bogard, Exxon Chemical Company
3. Thomas J. Detweiler, Chemical Industry Council of New Jersey
4. John P. Sandstedt, Sybron Chemicals Incorporated
5. William P. Hamilton, Merck & Co., Incorporated
6. Marcy McKinley, Fisher Scientific Company

The comments received and the Department's responses are summarized below. The number(s) in parenthesis after each comment identifies the respective commenter(s) listed above.

N.J.A.C. 7:27-8 General Comments

1. COMMENT: Two commenters expressed their appreciation for the Department's efforts to involve the regulated community and the public in the development of this innovative program and for providing incentives for encouraging pollution prevention. They said the modifications to subchapter 8 are an incentive for facilities to obtain a facility-wide permit. (1, 6)

RESPONSE: The Department acknowledges this support for the rule provisions.

2. COMMENT: Two commenters were concerned about the general nature and scope of the proposed rules. Much of these concerns dealt with the Department's approach of including an industrial facility's Pollution Prevention Plan in the facility-wide permit. One commenter (2) expressed the opinion that the proposed rules were a disincentive for volunteering to participate in the facility-wide permitting program and concluded that the Department's objective was to discourage participation in the program. Another commenter (3) urged the Department to delay any rules for the facility-wide permit program until the "pre-pilot" facility-wide permitting program, which is being conducted with three volunteer facilities, is completed.

RESPONSE: The scope and design of the facility-wide permit program and the proposed air rule revision is based on the policy direction embodied in the Pollution Prevention Act, the definition of "facility-wide permit" at N.J.S.A. 13:1D-37, and the implementing regulations at N.J.A.C. 7:1K. The legislative findings in the Pollution Prevention Act, N.J.S.A. 13:1D-36, and the definition of facility-wide permit, N.J.S.A. 13:1D-37, which specifies that the permit combines the air, water and hazardous waste permits and the appropriate provisions of the pollution prevention plan, provide a clear basis for incorporating Pollution Prevention Plans into the facility-wide permit program.

At this point, this approach is considered a "premise" or "theory" to be tested. The Department believes that this approach has the potential to increase the effciency and effectiveness of the permitting process. The Department will test this approach over the course of the pilot program to determine if it is successful and whether it should be expanded.

The revisions to N.J.A.C. 7:27-8 are intended to provide owners and operators of industrial facilities additional incentive for participating in

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the facility-wide permit program, not a disincentive as suggested by the commenters. The revisions to N.J.A.C. 7:27-8 have been developed in response to the contention by companies currently involved in the facility-wide permit program that the current "preapproval requirement" does not encourage industries to modify their operations for pollution prevention purposes. Removing the "preapproval requirement" is intended to provide an incentive to companies to aggressively pursue pollution prevention changes at their facilities without the possible hindrance of regulatory oversight. The Department's rationale for implementing the facility-wide permit program using volunteers was clearly stated during the rulemaking process for the Pollution Prevention Program rules (see 24 N.J.R. 3632, October 19, 1992). The Department will actively pursue volunteers for the facility-wide permit program until September 1993, pursuant to N.J.A.C. 7:1K-7.2(a).

The Department does not believe it is necessary to postpone the rules for implementing the pilot program until completion of the pre-pilot program. Since the Pollution Prevention Act contains specific milestones for completing the pilot program, the Department cannot significantly delay the rules and still meet the statutorily mandated deadlines. In addition, since the Department hopes to implement the pilot program using volunteers, it is important to provide potential volunteers with guidance before they make their decision to participate in the program. (See the adopted Pollution Prevention Program rules published in the March 1, 1993 issue of the New Jersey Register, 25 N.J.R. 930(a), for detailed comments on this issue.)

3. COMMENT: One commenter asserted that the Pollution Prevention Act does not authorize a Pollution Prevention Assessment and that N.J.S.A. 13:1D-41 specifically prohibits the Department from requiring information concerning non-hazardous substances. (2)

RESPONSE: The Department encourages owners and operators to consider cost-effective pollution prevention techniques for all substances, not just hazardous substances, but the commenter is correct that the Pollution Prevention Act does not require pollution prevention planning for non-hazardous substances. The term "Pollution Prevention Assessment" was developed to address concerns, raised by the pre-pilot facilities, that the Department should allow facilities to clearly separate processes that are "covered" by the Pollution Prevention Act from those processes that are not covered by the Act but are still part of the facility-wide permit. In addition, the Assessment provides an opportunity for an owner or operator to look at cost-effective pollution prevention techniques for non-hazardous substances and still receive the operational flexibility offered for hazardous substances.

While the Pollution Prevention Act does not specifically authorize a "Pollution Prevention Assessment" for non-hazardous substances, the Department does not interpret N.J.S.A. 13:1D-41 to limit an owner or operator's ability to look at pollution prevention opportunities for all of their production processes. Since the decision to conduct the Assessment is completely within the owner or operator's control, the Department believes the requirement for a Pollution Prevention Assessment is consistent with N.J.S.A. 13:1D-41.

4. COMMENT: One commenter (3) requested more information about what constitutes a Pollution Prevention Assessment. A second commenter (1) recommended clarifying the term "Pollution Prevention Assessment" to include all the elements of N.J.A.C. 7:1K-4.3 and 4.5 for those substances covered by the Department's existing regulations.

RESPONSE: As stated in the Summary to the proposed amendments, a Pollution Prevention Assessment is essentially the same thing as a plan modification. The Department agrees with the commenter's suggestion that the Pollution Prevention Assessment includes the elements set forth under N.J.A.C. 7:1K-4.3 and 4.5. The definition of Pollution Prevention Assessment specifically references these sections. Also, the Department agrees that the Pollution Prevention Assessment does not cover any substance that is not included in the facility-wide permit. For example, if a solid waste is generated and is not released to the air or water and is not regulated under RCRA or New Jersey's Hazardous Waste Regulations (N.J.A.C. 7:26-1.1), there would be no need to include the material in a Pollution Prevention Assessment.

5. COMMENT: One commenter stated that the Department failed to provide an estimate of the cost of preparing and sustaining a Pollution Prevention Assessment. (2)

RESPONSE: Please refer to the adopted Pollution Prevention Program rules, N.J.A.C. 7:1K, published in the March 1, 1993, issue of the New Jersey Register, 25 N.J.R. 930(a), for detailed responses on the cost issue, summarized below for informational purposes.

The Department expects that the unit costs of preparing a Pollution Prevention Assessment (that is dollars per process) will be similar to the costs of a Pollution Prevention Plan modification. However, since a plan modification or Pollution Prevention Assessment will likely be prepared for a specific process or separate area of a facility, the total aggregate costs are expected to be less than the facility's initial five-year Pollution Prevention Plan.

The cost of preparing a Pollution Prevention Plan was investigated during the drafting of the Pollution Prevention Program Rules, N.J.A.C. 7:1K. The Department concluded that there was limited detailed information available on plan preparation costs and that these costs may vary considerably from facility to facility depending on such factors such as the size of the facility, the number of "production processes," the number of covered hazardous substances and the adequacy of current materials tracking.

Based on the cost information available, the Department offered the following estimates for preparing a Pollution Prevention Plan:

$13,000 to $27,000 for small facilities
$22,000 to $45,000 for medium-sized facilities
$31,000 to $63,000 for large facilities

For several medium to large facilities, the one-time costs of preparing a pollution prevention plan are expected to range from $10.00 to $330.00 per employee and for 0.0007 percent to 0.03 percent of 1992 sales. The 1992 sales figures are from the Star-Ledger (September 20, 1992) and the American Business Directory.

6. COMMENT: Two commenters suggested that the requirement for a Pollution Prevention Assessment outweighed the other incentives for receiving a facility-wide permit provided by the rule revision. One commenter (2) stated that the economic benefit from a lower permit fee for an "amendment" versus an "alteration" would only arise if the Pollution Prevention Assessment were not required and if the permit conditions and supporting data were made compatible with the Federal Clean Air Act site-wide permits.

RESPONSE: Pollution prevention techniques usually prove to be cost-effective solutions that save money for the facility. The Department expects that the initial costs of preparing the plan modification or pollution prevention assesssment will be offset by benefits from implementing pollution prevention. These benefits need to be considered along with the reduced permit fee to determine the total benefit to the facility for participating in the program. On balance, therefore, the Department disagrees that the Pollution Prevention Assessment requirement outweighs the other incentives for receiving a facility-wide permit provided by the rule revision.

The Department will coordinate the development of facility-wide permits with the requirements for operating permits under Title V of the Clean Air Act Amendments (proposed as New Jersey's N.J.A.C. 7:27-22 elsewhere in this issue of the New Jersey Register). The Department will consult EPA on how these permits can be combined and whether the facility-wide permit could be considered the operating permit as an incentive for participating in the program.

7. COMMENT: The Department should further expand its definition of "amendment," N.J.A.C. 7:27-8.1. Operating changes that would reduce emissions should be allowed as an "at risk" amendment. (2)

RESPONSE: Within the parameters established by the Air Pollution Control Act, the Department may modify its interpretation of the terms "alteration" and "amendment" through rulemaking. The definitions of these terms have been changed several times through rulemaking over the past few years to provide additional operating flexibility. The last two changes included provisions to allow more permit changes to be processed as amendments, rather than alterations. The Department is considering further changes and expects to propose expanded use of the amendment procedure for voluntary installation of control devices. The rule provision adopted herein further expands the use of the amendment process to pollution prevention measures which do not increase any media impacts. However, the Department cannot allow any "operational changes" to be made "at risk" at a facility without a facility-wide permit because the Air Pollution Control Act requires permits to be issued for these changes to ensure that advances in the art of air pollution control are incorporated. The Department interprets the criteria being adopted at N.J.A.C. 7:27-8.27(a), used in conjunction with the pollution prevention planning process, as being equivalent to advances in the art of air pollution control.

8. COMMENT: The sixth paragraph of the summary states, "The plan modification would identify **any** changes in the inventory." This statement is incorrect; only increases to the inventory need be reported using a Plan Modification. (2)

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RESPONSE: The adopted rules for the Pollution Prevention Program, published in the March 1, 1993, issue of the New Jersey Register, 25 N.J.R. 930(a), identify those activities that trigger a Pollution Prevention Plan modification. These are paraphrased below:

1. Ceasing operation of a targeted production process or significantly expanding the operation of a targeted production process;
2. Installing a new and different primary component in a targeted production process or removing a primary component from a targeted production process unless the change was for pollution prevention.
3. Using, releasing, or generating hazardous substances as nonproduct output at a targeted production process which was not used, released or generated when the current Pollution Prevention Plan was completed;
4. Reclassifying an existing nonproduct output as a product, intermediate product, or co-product;
5. Modifying a grouping decision that affects a targeted process;
6. Modifying a targeting decision; or
7. Updating a facility Pollution Prevention Plan, Pollution Prevention Plan Summary, or Pollution Prevention Plan Progress Report.

This list clearly does not limit Plan modifications to increases to the inventory. Therefore, the Department disagrees with the commenter.

9. COMMENT: One commenter supported the approach of the Department that allows companies to make equipment changes as amendments, instead of alterations, when the change results in pollution prevention. The commenter felt that these types of rule changes encourage pollution prevention and allow for the changes to be made more quickly. The commenter asserted that this concept should be allowed for all facilities and not limited to only those facilities with facility-wide permits. (5)

RESPONSE: The Department agrees that it should allow equipment changes that will reduce releases to the environment to be made quickly. A facility-wide permit is a multi-media permit (covering air, water, and hazardous waste) which provides the Department with a tool to track relative changes in all wastes generated. By contrast, an amendment to a standard single-medium subchapter 8 permit does not currently take into account whether there is an increase in the generation of nonproduct output per unit of production for any medium. The Department is testing new approaches as part of the pilot program for facility-wide permitting. Before expanding the program to other facilities, the result of the program need to be evaluated to determine if this and other changes are effective. The Department is, by statute, limited to 10 to 15 facilities for the pilot program. See N.J.S.A. 13:1D-48.

The Department is very interested in exploring regulatory changes that will promote pollution prevention. The Department has committed itself to developing an agenda for pollution prevention regulatory reform in an incentives white paper it intends to publish in March 1994. However, some of these regulatory changes are being implemented on a "test" basis first to determine the extent to which the regulatory change, such as the one proposed for the air rules, provides incentives to pollution prevention and does not detract from protection of the environment. As such, the application of the air rule revision to the companies involved in the facility-wide permit program is considered a "test" and, depending on its outcome, may drive future revisions to air regulations on a broader basis.

N.J.A.C. 7:27-8.1 Definitions

1. COMMENT: All definitions in proposed N.J.A.C. 7:27-8.1 should reference N.J.A.C. 7:1K so that if there are any differences or if N.J.A.C. 7:1K should change, N.J.A.C. 7:27-8.1 would be consistent with the Pollution Prevention Program Rules. Furthermore, those comments submitted by CIC/NJ on December 4, 1992, regarding the "Definitions" contained in the proposed N.J.A.C. 7:1K are, as appropriate, included herein by reference. (2)

RESPONSE: The Department agrees with the commenter that the N.J.A.C. 7:27-8.1 definitions which pertain to the Pollution Prevention Program should reference N.J.A.C. 7:1K. Comments submitted regarding proposed N.J.A.C. 7:1K were addressed in the adoption document for that rule published in the March 1, 1993, issue of the New Jersey Register, 25 N.J.R. 930(a).

2. COMMENT: One commenter requested that the co-product, intermediate product, and nonproduct output definitions in proposed N.J.A.C. 7:27-8.1 be deleted from the proposed rule because, in general, these streams are not part of the air permit application. In addition, the commmenter repeated concerns previously expressed with these definitions when they were adopted in the Pollution Prevention Program rules. The commenter stressed that any activity that reduces the impact of a hazardous substance on the environment and reduces the load to treatment/disposal capacity should be credited as a nonproduct output reduction. (3)

RESPONSE: Nonproduct output is a new criterion for deciding if a change is an alteration or amendment that was proposed for addition to the rule at N.J.A.C. 7:27-8.27(a)3i. Therefore, a definition of the term had to be added to N.J.A.C. 7:27-8.1. The terms "intermediate product" and "co-product" are directly related to the definition of nonproduct output and the definitions of these terms are being added to help clarify the definition of nonproduct output. In drafting the Pollution Prevention Program Rules, N.J.A.C. 7:1K, the Department developed definitions for "co-product" and "intermediate product" to help address market fluctuations for materials which are not necessarily the intended results from a process but may occasionally be sold. The Department wanted to provide flexibility for these materials so they were not counted as "nonproduct output," but did not intend that the sale of these materials be considered pollution prevention. The Department provided detailed responses to the same comments raised by this commenter in the proposed Pollution Prevention Program rules N.J.A.C. 7:1K-1.1 (see 24 N.J.R. 3622) and in the adoption notice for those rules published in the March 1, 1993, issue of the New Jersey Register, 25 N.J.R. 930(a).

3. COMMENT: One commenter questioned why the definition of "effluent limitation," which is a wastewater concern, was included in a proposed air rule revision. (3)

RESPONSE: The term "effluent limitation" is being adopted as a criterion to decide if a change is an alteration or an amendment at N.J.A.C. 7:27-8.1(a)3iii. Therefore, a definition of the term is needed in 7:27-8.1. Pollution prevention and facility-wide permitting are, by nature, multi-media. The policies, procedures, rules and regulations used to implement the facility-wide permitting program will begin to take a multi-media focus. This means that issues which may impact one environmental medium (that is, water) may be included in regulations, such as N.J.A.C. 7:27-8.27, that concern another medium (that is, air or hazardous waste). This is a change to current regulations and methods used for permitting environmental releases. The Department will be testing these types of approaches during the facility-wide permitting program to determine if they are feasible. When the pilot program is complete, the Department will make recommendations on whether the multi-media control methods tested during the program were successful and whether facility-wide permitting should be expanded beyond the pilot program.

4. COMMENT: One commenter raised concerns regarding the inclusion of recycling in the definition of pollution prevention. The same comments were also made during the promulgation of the Pollution Prevention Program Rules, N.J.A.C. 7:1K. To summarize, the commenter contended that recycling has many of the same benefits as pollution prevention and that any recycling activity that reduces the quantity of hazardous substance on the site should be considered pollution prevention. (3)

RESPONSE: The issues raised by the commenter concerning the relationship between recycling activities and pollution prevention were discussed in detail during promulgation of the Pollution Prevention Program rules, N.J.A.C. 7:1K. Based on the definition of pollution prevention at N.J.S.A. 13:1D-37, which specifically excludes out-of-process recycling from being considered pollution prevention, but includes in-process recycling, the Department did not include all rcycling activities in the adopted definition of pollution prevention. The Department adopted a definition of in-process recycling which provides flexibility for certain batch operations which are conducted using dedicated and fixed equipment. (Please refer to the proposal at 24 N.J.R. 3609(a) and the adoption notice published in the March 1, 1993 issue of the New Jersey Register, 25 N.J.R. 930(a), for a detailed discussion of the issues concerning recycling and pollution prevention.)

N.J.A.C. 7:27-8.27 Exemption for pollution prevention alterations at facilities subject to N.J.S.A. 13:1D-35

1. COMMENT: One commenter requested that the stipulation in proposed N.J.A.C. 7:27-8.27, that a change cannot increase the amount of nonproduct output generated per unit of product, be deleted. This comment asserted that the definitions of nonproduct output and in-process recycling in the pollution prevention rules are too confusing and that it is possible that nonproduct output per unit of product could be increased, even though total releases, concentration or emission rate (to air or water) is decreased. The commenter suggested that the N.J.A.C. 7:27-8.27 stipulation be limited to releases per unit of product. (5)

RESPONSE: The Department does not believe there is a need to remove the terms "nonproduct output" and "in-process recycling" from

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the adopted revision to N.J.A.C. 7:27-8.27. The Department believes that the definitions of the terms adopted in N.J.A.C. 7:1K are clear and that the discussion in the March 1, 1993, issue of the New Jersey Register, 25 N.J.R. 930(a), helps to further clarify these terms. The same definitions have been incorporated into N.J.A.C. 7:27-8.27 with an added reference to N.J.A.C. 7:1K. Therefore, any changes to the definitions in N.J.A.C. 7:1K will be incorporated by reference into the definitions in these air rules.

The Department does not agree that the criteria for determining whether a proposed equipment change is an alteration or an amendment should be based on releases per unit of product. Rather, the additional flexibility provided by the rule amendment is appropriately based on allowing changes to equipment or control apparatus if pollution prevention techniques are considered and multi-media impacts are minimized. Since pollution prevention achievements are measured using nonproduct output per unit of product, if the criteria were limited to releases per unit of product, pollution prevention considerations would be eliminated. Nonproduct output is a more accurate measure of the efficiency of a process and the total contaminants or pollutants being generated at the source rather than releases because it does not count release reductions due to treatment. Since treatment does not improve the efficiency of the process or the actual generation of contaminants, it is not pollution prevention.

Although the commenter asserts that it is possible to increase nonproduct output per unit of product even though total releases to air or water are decreased, the Department believes that this situation will occur only if a change results in a cross-media shift where releases to one medium are decreased in favor of increased releases to another. The Department wants to avoid cross-media shifts of releases and does not intend to offer additional flexibility to allow such changes to go forward without pre-approval.

2. COMMENT: One commenter suggested that the reference to nonproduct output per unit of product in N.J.A.C. 7:27-8.27(a)3i should refer only to materials regulated under existing regulations. This commenter contended that the proposed rule revision would add an undue burden for no useful purpose if all materials were considered nonproduct output. (1)

RESPONSE: The Department did not intend to require all materials generated from a process to be counted as nonproduct output for the purposes of this rule revision. Consistent with the Pollution Prevention Act, only the hazardous and non-hazardous substances regulated by the facility-wide permit need to be included in the quantities of nonproduct output generated from a process.

3. COMMENT: There is confusion about whether the allowed Air Pollution Control operating changes under a site permit, that would otherwise be denied, are to be considered "amendments" or "alterations." Which term is being redefined or are such alterations to be considered amendments for the purposes of a site-wide permit? (2)

RESPONSE: Under the adopted amendments to N.J.A.C. 7:27-8, certain changes made to equipment and control apparatus are classified as an "amendment" rather than an "alteration," resulting in a reporting requirement, rather than a preconstruction approval requirement. No changes which would "otherwise be denied" are authorized under these amendments.

4. COMMENT: There appears to be a conflict between proposed N.J.A.C. 7:27-8.27(a) and N.J.A.C. 7:27-8.27(a)1. In proposed N.J.A.C. 7:27-8.27(a), it is stated that a permit is not required for "new equipment or control apparatus," while in proposed N.J.A.C. 7:27-8.27(a)1, "the equipment or control apparatus" must first have been identified in the facility-wide permit. How can "new equipment or control apparatus" be identified in a facility-wide permit prior to the purchase of same? Such new installations should be exempt from requiring a revised facility-wide permit if the "production process using the equipment or control apparatus are identified in ... a facility-wide permit ...." (2)

RESPONSE: Under proposed N.J.A.C. 7:27-8.27(a), the Department intended to exempt the installation of new equipment or control apparatus from the requirement of air pollution control permit or certificate if it is to be included in an existing process, which is included in the facility-wide permit, and meets the other criteria stated in the rule. The new equipment or control apparatus cannot be installed without an air pollution control permit or certificate, if that equipment or control apparatus is to be installed and operated outside the umbrella of the pollution prevention facility-wide permit. The adopted language at N.J.A.C. 7:27-8.27(a)1 has been clarified in response to this comment in order to eliminate any confusion about this issue.

5. COMMENT: Two commenters asserted that proposed N.J.A.C. 7:27-8.27(a) requires a company to attempt to identify and incorporate any and every new process or product, which might be developed during the term of the permit, into the application. The commenters also asserted that this flexibility is now available under the batch plant permitting procedures for air pollution control. The commenters stated that it is impossible to include all the new products, which might be manufactured in the future, in the permit application. The commenters suggested that N.J.A.C. 7:27-8.27(a)1 through (a)3iii would address any concerns, relative to allowing a new process which may increase releases, the Department may have. These provisions of the rule would not allow new production processes to be added as an amendment. (3,4)

RESPONSE: The commenters are correct that the batch plant permit procedure previously developed by the Department already provides significant operating flexibility. Similar flexibility is now provided for facility-wide permits through this adoption in that a new product for an existing production process, which is covered under a facility-wide permit, can be added to the facility-wide permit as an amendment. As for batch permits, there are other restrictions to observe, such as adding a new category of air contaminant. Adding a new production process, however, cannot be handled as an amendment in either case.

Summary of Hearing Officer's Recommendations and Agency Response:

John Weingart, Assistant Comissioner of Environmental Regulation, served as the hearing officer at the January 11, 1993, public hearing held at the Department of Environmental Protection and Energy building in Trenton, New Jersey. After reviewing the oral testimony presented at the public hearing, Assistant Commissioner Weingart recommended that the Department adopt the rules at N.J.A.C. 7:27-8 as proposed, with minor changes as described above in the Summary of Public Comments and Agency Responses and below in the Summary of Agency-Initiated Changes. The Department accepts the recommendation.

A copy of the record of public hearing, which includes the hearing officer's report, is available upon payment of the Department's normal charges for copying. Persons requesting copies should contact:

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and Energy
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Summary of Agency-Initiated Changes:

Additional changes have been made on adoption to clarify the amended rules. These changes make this rule consistent with the adopted Pollution Prevention Program Rules, N.J.A.C. 7:1K, published in the March 1, 1993, issue of the New Jersey Register, 25 N.J.R. 930(a).

1. On adoption of N.J.A.C. 7:27-8.1, Definitions, the Department has made the following clarifications to make these definitions consistent with those in N.J.A.C. 7:1K:

A. The definition of "co-product" has been changed to read "one or more incidental result(s) of a production process ..."

B. The definition of "intermediate product" has been changed to read "one or more desired result(s) of a production process that is made into a product in a subsequent production process at the same industrial facility, without the need for pollution treatment ..."

C. The definition of "Pollution Prevention Plan" has been changed to read "pursuant to N.J.S.A. 13:1D-41 and 42 ..."

D. The definition of "product" has been changed to read "... one or more desired result(s) of a production process ..."

2. On adoption, the Department is clarifying the reference to the Pollution Prevention Act in N.J.A.C. 7:27-8.27 by changing the citation from N.J.S.A. 13:1D-37 to N.J.S.A. 13:1D-35 et seq., referring to the Pollution Prevention Act in its entirety rather than only the definitions section.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

7:27-8.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

...

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"Co-product" means *[an]* ***one or more*** incidental result***(s)*** of a production process that is not a primary product of the production process and that is sold in trade in the channels of commerce to the general public in the same form as it is produced, for any purpose except the purpose of energy recovery. A co-product is not considered nonproduct output. Increases in quantities of co-products do not count towards use reduction or nonproduct output reduction goals. ***This term shall have the same meaning as defined for the term "co-product" at N.J.A.C. 7:1K-1.5.***

. . .

"Effluent limitation" means any restriction on quantities, quality, discharge rates, concentration of chemical, physical, thermal, biological, or other constituents of a pollutant *[as defined in N.J.A.C. 7:14A-1.9]*. ***This term shall have the same meaning as defined for the term "effluent limitation" at N.J.A.C. 7:14A-1.9.***

. . .

"Facility-wide permit" means a single permit issued by the Department to the owner or operator of a priority industrial facility incorporating the permits, certificates, registrations, or any other relevant Department approvals previously issued to the owner or operator of the priority industrial facility pursuant to the Solid Waste Management Act, N.J.S.A. 13:1E-1 et seq., the Water Pollution Control Act, N.J.S.A. 58:10A-1 et seq., the Air Pollution Control Act, N.J.S.A. 26:2C-1 et seq., and the appropriate provisions of the Pollution Prevention Plan prepared by the owner or operator of the priority industrial facility pursuant to N.J.S.A. 13:1D-41 and 42. ***This term shall have the same meaning as defined for the term "facility-wide permit" at N.J.A.C. 7:1K-1.5.***

. . .

"Intermediate product" means *[a]* ***one or more*** desired result ***(s)*** of a production process that is made into a product in a subsequent *[processing step]* ***production process*** at the same industrial facility, without the need for ***pollution*** treatment prior to its being made into a product. An intermediate product is not considered nonproduct output. Increases in quantities of intermediate products do not count towards use reduction or nonproduct output reduction goals. ***This term shall have the same meaning as defined for the term "intermediate product" at N.J.A.C. 7:1K-1.5.***

. . .

"Nonproduct output" or "NPO" means all hazardous substances or hazardous wastes that are generated prior to storage, out-of-process recycling, treatment, control or disposal, and that are not intended for use as a product. NPO includes fugitive releases. ***This term shall have the same meaning as defined for the term "nonproduct output" at N.J.A.C. 7:1K-1.5.***

. . .

"Pollution Prevention Assessment" means an assessment of potential pollution prevention opportunities for the use, generation and release of non-hazardous substances, prepared by an owner or operator of a priority industrial facility that is covered by an effective facility-wide permit issued by the Department, containing the same elements as those required for hazardous substances by N.J.A.C. 7:1K-4.3 and 4.5. ***This term shall have the same meaning as defined for the term "Pollution Prevention Assessment" at N.J.A.C. 7:1K-1.5.***

"Pollution Prevention Plan" means a plan required to be prepared by an industrial facility pursuant to N.J.S.A. 13:1D-41 ***and 42***, N.J.A.C. 7:1K-3 and N.J.A.C. 7:1K-4. ***This term shall have the same meaning as defined for the term "Pollution Prevention Plan" at N.J.A.C. 7:1K-1.5.***

. . .

"Product" means *[a]* ***one or more*** desired result***(s)*** of a production process that is used as a commodity in trade in the channels of commerce by the general public in the same form as it is produced. Products include intermediate products transferred to a separate industrial facility owned or operated by the same owner or operator. ***This term shall have the same meaning as defined for the term "product" at N.J.A.C. 7:1K-1.5.***

"Production process" means a process, line, method, activity or technique, or a series or combination of processes, lines, methods or techniques, used to produce a product or reach a planned result. ***This term shall have the same meaning as defined for the term "production process" at N.J.A.C. 7:1K-1.5.***

. . .

7:27-8.3 General provisions

(a) No person shall construct, install, or alter any equipment or control apparatus without first having obtained a Permit to Construct, Install or Alter Control Apparatus or Equipment, except as provided at N.J.A.C. 7:27-8.27.

(b) No person shall use or cause to be used:

1. Any new or altered equipment or control apparatus without first having obtained an operating certificate or a temporary operating certificate, except as provided at N.J.A.C. 7:27-8.27; or

2. (No change.)

(c)-(j) (No change.)

7:27-8.27 Exemption for pollution prevention alterations at facilities subject to N.J.S.A. 13:1D-*[37]****35 et seq.***

(a) A person is not required to obtain a permit or a certificate for an alteration of equipment or control apparatus, or installation of new equipment or control apparatus, if:

1. *[The equipment or control apparatus, and the]* ***The*** production process using the equipment or control apparatus, *[are]* ***is*** identified in and subject to an approved facility-wide permit issued under N.J.S.A. 13:1D-*[37]****35 et seq.***;

2. The alteration or installation is either:

i. Allowed under the facility-wide permit; or

ii. Documented in a modification to a Pollution Prevention Plan, which satisfies the requirements of N.J.A.C. 7:1K-3 and 4, or in a Pollution Prevention Assessment as defined in N.J.A.C. 7:1K-1.5; and

3. The alteration or installation does not cause any of the following:

i. An increase in the generation of nonproduct output per unit of production manufactured by the equipment or production process;

ii. An exceedance of the maximum allowable concentration or rate of emission of any air contaminant for the production process or the entire facility, whichever is more stringent;

iii. An exceedance of the maximum allowable concentration or effluent limitation of any discharge to waters of the State; or

iv. The addition of a new production process.

(b) Any person who is exempted pursuant to (a) above from obtaining a permit and certificate shall report the alteration or change and the Pollution Prevention Plan Modification or Pollution Prevention Assessment to the Department within 120 days after the occurrence of the alteration or change, as an amendment of the facility-wide permit pursuant to the procedures for amendment at N.J.A.C. 7:27-8.3(c).

(c) For equipment or control apparatus subject to (a) above, the facility-wide permit shall constitute the operating certificate required by this chapter.

HIGHER EDUCATION

(a)

NEW JERSEY HIGHER EDUCATION ASSISTANCE AUTHORITY (NJHEAA)

Student Loans: Procedures and Policies

Readoption with Amendments: N.J.A.C. 9:9

Proposed: June 7, 1993 at 25 N.J.R. 2187(a).

Adopted: August 16, 1993 by the New Jersey Higher Education Assistance Authority, Warren Smith, Chairman.

Filed: August 16, 1993 as R.1993 d.441, **with substantive and technical changes** not requiring additional public notice and comment (See N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 18A:72-10.

Effective Date: August 16, 1993, Readoption;
September 7, 1993, Amendments.

Expiration Date: August 16, 1998.

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Summary of Public Comments and Agency Responses:
No comments received.

Summary of Changes Made upon Adoption:
Proposed amendments to N.J.A.C. 9:9-1.6 and 9:9-9.4(a)5 would have increased the insurance fees paid by borrowers to the Authority from one percent to three percent. Subsequent to the publication of the proposed amendments, the Authority learned that guarantors will soon be limited to one percent or less insurance fees under Federal law. The costs associated with increasing fees to three percent for a short period have led the Authority to conclude that an increase to three percent insurance fees is not desirable. Therefore, these proposed changes will not be adopted.

The deletion of the reference to graduate students in the definition of "Federal PLUS Loan" in N.J.A.C. 9:9-1.1 is being made to correct an error in the proposal. PLUS is a Federal program that does not permit loans for graduate study.

In N.J.A.C. 9:9-7.2(b), an addition of the reference to the borrower is being made to conform to language used elsewhere in the regulations governing NJCLASS. Parents are not the only eligible borrowers in the program.

A typographical error in the proposal is being corrected in N.J.A.C. 9:9-9.4.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 9:9.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

9:9-1.1 Definitions

(a) The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

. . . .

"Delinquency" means the failure of the borrower to make a payment when due. Delinquency begins the day after a payment is due and continues for a period up until the loan meets the definition of default.

"Federal Family Education Loan program" shall mean the Federal Stafford Loan, Federal Supplemental Loans for Students, Federal PLUS Loan, and Federal Consolidation Loan program.

"Federal PLUS Loan" is a loan program targeted for parents of dependent undergraduate *[or graduate]* students. Formerly known as PLUS Loans, all Federal PLUS loans were made on or after July 23, 1992.

"Federal SLS Loan" is a loan program targeted for independent undergraduate students, graduate students, and dependent undergraduates whose parents are unable to procure a Federal PLUS Loan. Formerly known as SLS loans, all Federal SLS loans were made on or after July 23, 1992.

"Federal Stafford Loan" is a loan program which includes Stafford Loans and Unsubsidized Federal Stafford Loans for Middle-Income Borrowers.

. . . .

"PLUS" was a loan program which was targeted for parents of dependent undergraduate or graduate students. All PLUS loans were made before July 23, 1992.

"Servicer" means a third party with whom the lender/holder has entered into a contract, through assignment, transfer or sale, to handle specific aspects on student loans on the lender/holder's behalf in accordance with the Federal Family Education Loan program regulations.

"SLS" was a loan program targeted for independent undergraduate students, graduate students, and dependent undergraduate students whose parents were unable to procure a PLUS loan. All SLS loans were made before July 23, 1992.

(b) (No change.)

9:9-1.2 Loan amounts

(a) Annual and aggregate loan amounts that may be borrowed shall be in accordance with 34 C.F.R. 682.204.

(b) No student shall be permitted to borrow a second time for the same stated grade level in school, as indicated on the previous loan application, if the request is the result of either academic failure or the failure to complete a full-time course load for the stated grade level at the institution attended; provided, however, that the Authority shall have the discretion to permit borrowing a second time for the same grade level in school when, at the discretion of the Authority, the borrower's request for repetitive funding is substantially based upon circumstances which were beyond his or her immediate control.

9:9-1.5 Change of lenders

(a) A student should obtain all loans from the same lender. If the student is unable to do so, the student must notify the Authority in writing of a change of lenders.

(b) The Authority, as required by Federal regulation, will make every reasonable effort to ensure that the borrower's loans are obtained and maintained from the same lender, holder, guaranty agency, and servicer to eliminate the need for multiple contacts with the borrower. If the borrower is unable to obtain loans from the same lender, alternative application processing will be available from the Authority and lenders for the borrower.

9:9-1.6 Insurance and origination fees

(a) An applicant for a student loan must:

1. Pay an insurance fee of *[three]* ***one*** percent of the principal balance of the loan in accordance with 34 C.F.R. 682.202. Any adjustments or refunds hall be made by the lender or the Authority. The fee is only charged upon disbursement; however, the fee is not charged twice if the student changes schools within the same academic year;

2. Pay an origination fee based upon a rate assigned by Federal guidelines, in accordance with 34 C.F.R. 682.202, on the principal amount of the loan. Refunds shall be made by the lender in accordance with promulgated Federal guidelines.

(b) (No change.)

(c) No educational institution may charge an applicant a fee for processing an application for a Federal Family Education Loan.

(d) For Unsubsidized Federal Stafford Loans for Middle-Income Borrowers, applicants must pay a combined origination fee and insurance premium to the Federal government, based upon a rate outlined in 34 C.F.R. 682.202, on the principal amount of the loan.

9:9-1.8 Securing the note

Prior to approval of the loan, the lender must secure the student's signature on the application/note. The forms provided by the Authority must be used in all cases except when prior approval by the Authority has been given to the lender's form. Lenders shall adhere to the provisions outlined in 34 C.F.R. 682.206.

9:9-1.9 Disbursement procedures

(a) The disbursement of funds shall be made by a check made jointly payable to the borrower and the school and must be sent directly to the school by the lender, or by means of electronic funds transfer, and in accordance with Federal regulation 34 C.F.R. 682.207.

(b) (No change in text.)

9:9-1.10 Change of school before disbursement

If, prior to disbursement of funds, the applicant indicates he or she will be attending a school other than the one indicated on the application he or she must notify the lender orally or in writing to cancel the loan application. The loan is not transferable from school to school. Another application for the new school must be completed. No insurance fee will be charged if amounts remain the same.

9:9-1.11 Interest

Lenders may charge, calculate or accept payment of interest in accordance with Federal regulation 34 C.F.R. 682.202.

9:9-1.12 Repayment of loan; installment arrangements

Repayment of all student loans must be in accordance with Federal regulation 34 C.F.R. 682.209.

9:9-1.13 Delinquent payments; responsibility of lender

When an account becomes delinquent as a result of nonpayment of an installment when due or failure to return funds due to nonenrollment in school, the Authority must be notified of such an event

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at the time of occurrence and the lender must follow the provisions of Federal regulation 34 C.F.R. 682.410.

9:9-1.14 Late charges

Except where authorized by Federal regulation 34 C.F.R. 682.202, late charges are not permitted on any notes which compute simple interest on a daily basis.

9:9-1.15 Notification of bankruptcy proceedings

In the event the lender is notified of any bankruptcy proceedings against the borrower subsequent to purchase of the defaulted loan by the Authority, the lender shall be responsible for filing a bankruptcy claim with the guarantee agency within 30 days of the date the lender determines that collection has been stayed.

9:9-1.16 Procedure for filing claim

(a) With loans defined as being in a default status, a claim form provided by NJHEAA may be submitted upon expiration of the required default time period as set forth in Federal regulations provided the lender has been in compliance with all Federal and State due diligence regulations.

(b) More than one loan, of the same type, may be combined on one claim form as long as the interest rate is the same. The lender will be reimbursed for the total unpaid principal and interest due for a period not to exceed 90 days beyond the date of default. The original note(s), properly assigned to the Authority, must be forwarded with the claims. By law, the Authority may not reimburse the lender for late charges.

9:9-1.19 Certification of student enrollment in school

If a lender suspects a student is no longer attending the institution stated on the most recent application, steps shall be taken immediately by the lender to verify this data in the following manner. The lender shall communicate with the student requesting written evidence of current status from the school and shall simultaneously notify the Authority.

9:9-1.22 Records and access requirements

Each participating lender/servicer shall maintain records, and allow NJHEAA (the Authority), the Secretary (USDE), and the Secretary's designee access to those records, as outlined in 34 C.F.R. 682.414(a)(3).

SUBCHAPTER 2. FEDERAL FAMILY EDUCATION LOAN PROGRAM STATUTES AND REGULATIONS

9:9-2.1 Rules and statutes incorporated by reference

(a) The part of the Code of Federal Regulations known as 34 C.F.R. 682.100 through and including 34 C.F.R. 682.840 (as of July 23, 1992) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within these regulations.

(b) The part of the United States Code known as Title 20, Chapter 28, Subchapter IV, Part B, 20 U.S.C. 1071 through and including 1087e3 (as of March 1, 1990) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within these regulations with the modifications indicated in (c) below:

(c) (No change.)

SUBCHAPTER 3. POLICY GOVERNING FEDERAL PLUS AND FEDERAL SUPPLEMENTAL LOANS FOR STUDENTS (SLS) LOAN PROGRAMS

9:9-3.1 Rules and statutes incorporated by reference

(a) The part of the Code of Federal Regulations known as 34 C.F.R. 682.100 through and including 34 C.F.R. 682.840 (as of July 23, 1992) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within these regulations.

(b) The part of the United States Code known as Title 20, Chapter 28, Subchapter IV, Part B, 20 U.S.C. 1071 through and including 1087e3 (as of March 1, 1990) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within these regulations.

(c) The provisions of N.J.A.C. 9:9-1, governing the Federal Family Education Loan Program shall also apply to loans made under the Federal PLUS/SLS programs unless they are inconsistent with or otherwise excepted within the provisions of this subchapter.

9:9-3.2 Eligibility

An applicant for a Federal PLUS or Federal SLS loan must meet the requirements set forth in 34 C.F.R. 682.201.

9:9-3.3 Insurance fee and origination fee

(a) An applicant for a Federal PLUS or Federal SLS loan must pay the insurance fee as prescribed in 34 C.F.R. 682.202.

(b) No applicant for a Federal PLUS or Federal SLS loan, with a first disbursement prior to October 1, 1992, shall be charged an origination fee as prescribed in 34 C.F.R. 682.202.

(c) Applicants for a Federal PLUS or Federal SLS loan, with a first disbursement on or after October 1, 1992, shall be charged an origination fee as set forth in 34 C.F.R. 682.202.

9:9-3.4 Disbursement

Disbursement of funds must be in accordance with provisions set forth in 34 C.F.R. 682.207.

Recodify N.J.A.C. 9:9-3.4 as 3.5 (No change in text.)

9:9-3.6 Capitalization of accrued interest

For Federal PLUS or Federal SLS loans insured under a guarantee agency program, a lender may add accrued interest and unpaid insurance premiums to the borrower's unpaid principal balance according to the institution's own billing cycle but in no case more frequently than quarterly as set forth in 34 C.F.R. 682.202.

9:9-5.1 Qualifications for eligibility

(a) To qualify for eligibility under this program, an applicant must:

1. Be a permanent resident of New Jersey for at least six months prior to filing an application;

2. Be enrolled or accepted for enrollment as a full-time student pursuing a graduate or professional degree beyond the baccalaureate level, attending a school approved by the Authority for medicine, osteopathy, dentistry, veterinary medicine, podiatry or optometry; and

3. (No change.)

9:9-6.1 Eligible lenders

Refinancing by an eligible lender or holder of student loans guaranteed by the Authority, shall be in conformance with all applicable Authority statutes, rules and regulations, as amended.

9:9-6.2 Written notification of transfer/refinance

Upon transfer or refinance of an Authority guaranteed note, an eligible lender or holder shall give written notification of such transfer/refinance in accordance with 34 C.F.R. 682.208(e).

9:9-6.3 (Reserved)

9:9-6.4 Consolidation loans

Consolidation loans shall be made in accordance with Federal regulations, 34 C.F.R. 682.

9:9-6.9 Rules and statutes incorporated by reference

(a) The part of the United States Code known as Title 20, Chapter 28, Subchapter IV, Part B, 20 U.S.C. §1078-3 through and including §1087e (as of March 1, 1990) including subsequent amendments and supplements is hereby adopted as rules and incorporated within these regulations.

(b) (No change.)

(c) Purchase of defaulted refinanced loans by the Authority shall be subject to all pertinent Federal and State requirements for the purchase of defaulted Federal Family Education Loan programs.

9:9-7.2 Eligibility

(a) To be eligible for a NJCLASS loan, each applicant must:

1. (No change in text.)

2. Not be in default on any student loan or had any prior student loan discharged; and

3. (No change in text.)

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(b) In addition to all of the requirements in (a) above, a student applicant or a student on whose behalf the parent ***and/or borrower*** is applying for a NJCLASS loan shall:

1.-3. (No change.)

4. Have exhausted or be ineligible for a subsidized Federal Stafford Loan.

9:9-7.3 Loan amounts

Recodify existing (c) through (d) as (a) through (b) (No change in text.)

9:9-7.4 Application procedure

(a)-(b) (No change.)

(c) Lender will disburse loan funds to parent and/or borrowers in one disbursement. Funds to a student borrower will be made jointly payable to the student and the eligible school, mailed directly to the school and may be multiply disbursed.

9:9-7.5 Fees

(a) A recipient of a NJCLASS loan shall be required to pay an application and administrative fee to the New Jersey Higher Education Assistance Authority which combined will not exceed five percent of the total approved loan amount.

1.-2. (No change.)

9:9-7.6 Interest

(a) The NJCLASS loan shall have a daily fixed simple annual interest rate. The NJCLASS interest rate will be a pass through rate of the bond interest rate, associated costs of sale, and such other costs which may be required, and/or determined as the bonds are issued. The interest rate will be published in the New Jersey Register after each bond issue.

(b)-(c) (No change.)

SUBCHAPTER 8. (RESERVED)

9:9-9.4 Application procedure; applicant

(a) An applicant for a *[dirct]* ***direct*** PLUS/SLS loan shall:

1.-4. (No change.)

5. Pay an insurance fee of *[three]* ***one*** percent of the requested amount of the loan. No refunds will be issued after the application has been approved by the Authority.

9:9-11.1 Standards

(a) (No change.)

(b) Individual institutions shall be periodically evaluated by an Authority program audit to confirm their program compliance. In the performance of this audit, auditors shall be given access to all records relative to student loans, in paper, microfiche or electronic formats according to industry standards, including, but not limited to:

1.-9. (No change.)

(c)-(e) (No change.)

9:9-11.4 Appeal procedure

(a) The Executive Director of the Authority is authorized to institute any corrective action set forth in N.J.A.C. 9:9-11.3. Any institution which is sanctioned shall have the right to appeal the Executive Director's action within 30 days of the date of the letter notifying the institution of the sanction.

(b) (No change.)

(c) To initiate the informal pre-hearing conference, the following procedure shall be utilized:

1. The petitioner shall file with the Executive Director a letter providing the essential facts giving rise to the contesting of the Authority imposed sanction and indicating its desire to appeal the determination.

2. Upon receipt of the letter outlined in (c) above, the Executive Director shall schedule a conference between representatives of the institution and members of the NJHEAA staff. The purpose of this conference is to allow mediation to narrow the dispute.

3. (No change.)

(d) To initiate a formal appeal, the following procedure shall be utilized:

1. The petitioner shall file with the Executive Director the original copy of a formal petition, together with proof of mailing.

2. The petition must state the name and address of the petitioner, and a statement of the essential facts and legal grounds giving rise to the contesting of the Executive Director's imposed sanction.

(e) The Executive Director shall bring the petition before the Authority in a timely manner. The petitioner may appear before the Authority but if it chooses not to do so the Executive Director shall notify the petitioner of the Authority's decision in the manner. The institution shall be provided with the opportunity for a hearing pursuant to the requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Pharmaceutical Services Manual

Adopted Repeal and New Rules: N.J.A.C. 10:51

Proposed: September 8, 1992 at 24 N.J.R. 3053(a).

Adopted: August 9, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: August 9, 1993 as R.1993 d.434, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6a(5)b(6); 30:4D-7, 7a, b, and c; 30:4D-12; 30:4D-20-22, 24; 1927 of the Social Security Act, 42 U.S.C. 1396r-8(a); 42 CFR 440.120.

Effective Date: September 7, 1993.

Expiration Date: September 7, 1998.

Summary of Public Comments and Agency Responses:

Written comments on the proposed new rules were submitted by the persons/organizations listed below:

Leon R. Langley, Pharmacist
Director of Government Affairs
New Jersey Pharmaceutical Assn.
Trenton, NJ

I. Barton Frenchman, R.P., F.A.S.C.P.
Pharmaceutical Rx Consultants, Inc.
Union, NJ

David A. Banta
Pharmaceutical Manufacturers Association
Washington, D.C.

The comment submitted by the New Jersey Pharmaceutical Association was detailed and addressed several issues, some of which were general concerns, with other comments directed to specific sections. Therefore, there will be several comments and agency responses necessary to reply to this one commenter.

1. COMMENT: The commenter had a general concern about payment to out-of-State pharmacies, especially with respect to out-of-State pharmacies participating in the PAAD program. The commenter recognized that some Medicaid patients, especially those placed out-of-State, would need to have prescriptions filled by an out-of-State pharmacy. The commenter requested a modification indicating that out-of-State pharmacies may be used only on a patient-by-patient basis.

RESPONSE: The agency's response is that there are two issues. First, the Medicaid rule should remain as is to enable Medicaid recipients to receive pharmacy services if they are out-of-State, as indicated in N.J.A.C. 10:49-6.2. Second, the agency's response is that out-of-State pharmacies cannot participate in the PAAD program pursuant to N.J.A.C. 10:51-4.2(b)1, which is being amended upon adoption to indicate specifically that out-of-State pharmacies with retail or institutional permits cannot participate in the PAAD program. This is a long-standing PAAD program requirement.

2. COMMENT: The commenter also had a general concern about the timely availability of drugs through various lists, including the MAC drug

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list, the DESI drug list, and the list of drugs covered in the Medicaid program under the drug manufacturer rebate program, and over-the-counter drugs covered in the Garden State Health Plan (GSHP). The commenter requested that the Division make available all lists with a timely notification system for updates.

RESPONSE: The agency's response is that the changes occur so frequently that it is difficult, if not impossible, to provide updates as rapidly as the changes occur. Many changes are the result of actions taken by the Federal Food and Drug Administration (FDA) and the Health Care Financing Administration (HCFA), in accordance with Federal Administrative procedures. Thus, this information is available through many sources. The Division will provide pharmacies with as much current information as the existing system permits.

The specific comments by the New Jersey Pharmaceutical Association are enumerated as discussed in the following paragraphs.

3. COMMENT: N.J.A.C. 10:51-1.6(b): The commenter was concerned about the completion of the form FD-70 regarding the maximum discount category. The commenter questioned whether a provider could withhold the annual prescription volume information.

RESPONSE: The agency's response is to agree with the commenter and amend the rule upon adoption to indicate that if the pharmarcy does not supply the required information, the maximum discount will be applied. The agency does not believe this change enlarges or curtails the scope of the rule and its impact on pharmacy providers. Providers are already required to complete and file the form FD-70. If the pharmacy providers choose not to complete one portion of the form regarding prescription volume, then the Division will apply the maximum discount, as indicated in the proposal. In essence, the Division has not changed its long-standing policy regarding pharmacies whose annual prescription volume exceed 50,000.

4. COMMENT: N.J.A.C. 10:51-1.8: Pharmacy providers are concerned about the complexities of compound prescriptions. The commenter suggested some alternative methods of administration, including the assignment of an NDC (National Drug Code) number to the most frequently ordered compound prescriptions, or the assignment of a "fake" NDC number in order to reduce the number of claims that require manaul processing.

RESPONSE: The agency chooses not to assign NDC numbers because the variability in the composition of prescribed compounds make NDC number assignment an impractical and difficult task. In addition, the Division still needs to be able to identify the non-covered ingredients within billed compounds, such as non-covered non-legend drugs, non-rebatable drugs or DESI drugs. Therefore, the Division does not wish to change the text of N.J.A.C. 10:51-1.8, as requested by the commenter.

5. COMMENT: N.J.A.C. 10;51-1.8(b)2i: The commenter was also concerned about the coverage of non-legend ingredients in compound prescriptions dispensed to Garden State Health Plan (GSHP recipients).

RESPONSE: The Division has added clarifying language to indicate that the coverage under GSHP includes coverage of all non-legend drug products, including those contained within a compound prescription. This is a recognition of existing policy. The rule limiting coverage of non-legend drugs to the general Medicaid population did not impose the same restriction on those persons enrolled in GSHP (Reference is made to R.1991, d.353, adopted at 23 N.J.R. 2035(a)).

6. COMMENT: N.J.A.C. 10:51-1.10: The commenter noted that there appeared to be conflict between the summary statement (24 N.J.R. 3054) and the text of the rule at 24 N.J.R. 3059 regarding "weighted average."

RESPONSE: The Division admits that the reference to "weighted average" was inaccurate and should not have been mentioned in the proposal summary. The reference to the pharmacy providers "usual and customary" charge in the text of the rule is correct and remains unchanged upon adoption.

7. COMMENT: N.J.A.C. 10:51-1.12(a)1: The commenter had several concerns about N.J.A.C. 10:51-1.12 regarding non-covered services. One concern was the prohibition of payment for prescriptions which are not for medically accepted indications as defined in Section 1927(k)(6) of the Social Security Act. The commenter was also concerned about an "abuser" patient who obtained drugs from several sources.

RESPONSE: The agency's response is that provider will be notified of prescriptions that are not medically indicated as defined in Federal law. The agency's response to the commenter's broader concern is that the cited regulation was meant to apply only to those drugs prohibited by Federal law. The agency also removed the parenthesis to clarify the scope of the rule.

8. COMMENT: N.J.A.C. 10:51-1.12(a)9: The commenter requested that pharmacies be supplied with a list of covered enteral nutritional products and electrolyte replacement supplements and full information on how to bill for each specific product.

RESPONSE: The Division's response is that the availability of trade literature and publications issued frequently by drug manufacturers allow the providers to have information regarding drug product and NDC number changes faster than if the Division published this information for providers. The changes in marketplace occur so quickly that such information when published by the Division, often becomes obsolete soon after publication. Weekly drug file updates to the New Jersey Medicaid Management Information System (NJMMIS) adequately maintains current files and the agency intends to continue with the current policy.

9. COMMENT: N.J.A.C. 10:51-1.12(b)3: The commenter again requests pharmacy providers be given notice of changes in products excluded from payment because they do not offer significant price or therapeutic advantage.

RESPONSE: The agency's response is that this section is being deleted upon adoption because the agency now covers all diabetic devices and testing materials. The removal of the exclusion should be beneficial to both providers and recipients.

10. COMMENT: N.J.A.C. 10:51-1.12(b)4: The commenter requested a waiver of payment for unit-dose packaged medications for residential care recipients.

RESPONSE: The agency's response is that the regulation should remain unchanged. The Division wishes to retain the restriction on unit-dose packaged medications to residential care recipients, unless the drug is only available through unit-dose packaging. The agency recognizes the potential advantages of unit-dose dispensing but believes it is not cost-effective to allow an exception for residential care recipients. The agency notes that residential care Medicaid recipients can and do receive medically necessary medications which are not packaged in unit doses.

11. COMMENT: N.J.A.C. 10:51-1.13(a)1: The commenter requested an extension of time to allow pharmacists to dispense more than a 72-hour supply of drugs when prior authorization from the Medicaid District Office (MDO) is not available. The commenter suggested that a five to seven day time period would be more appropriate.

RESPONSE: The agency response is that the MDO staff will apply discretion when determining prior authorization for drug quantities which exceed a 72-hour supply. Additional text has been added to N.J.A.C. 10:51-1.13(a)1 allowing for the provider to dispense the drug for a total of five days supply if the MDO is unavailable. If the drug is to be continued beyond either time period, the provider shall hold the claim and obtain prior authorization from the MDO during normal business hours. The agency believes this extension of time will benefit both recipients and providers.

12. COMMENT: N.J.A.C. 10:51-1.13(b)5: The commenter questioned the procedure for prescriptions issued by physicians who are not case managers in GSHP.

RESPONSE: The agency revised the language in N.J.A.C. 10:51-1.13(b)5 upon adoption to clarify the policy that those legend and non-legend drugs or devices prescribed by a physician as the result of a referral from a GSHP Physician Case Manager require prior authorization. The drugs will be covered so long as prior authorization is obtained. The Division's policy has been, and continues to be, that if the PCM prescribes a drug for a GSHP patient, then prior authorization is not required. However, if a physician, or other health care practitioner that is authorized to prescribe by law, prescribes a drug for a GSHP enrollee, then the "other prescriber" must obtain prior authorization from the PCM.

The amended language being inserted upon adoption is intended to clarify current policy.

13. COMMENT: N.J.A.C. 10:51-1.19(a)3: The commenter requested clarification of the "medical certification" requirement.

RESPONSE: The agency's response is to add text to N.J.A.C. 10:51-1.19(a)3 indicating that when a provider authorizes the dispensing of a brand MAC drug, the pharmacist shall indicate the prescribing preference by checking "Medical Certification" on the claim form and shall dispense and bill Medicaid for the prescribed product. Medical certification is indicated in order for the provider to receive a drug's cost equal to the (AWP) of the brand product dispensed. In essence, the pharmacist must check "medical certification" (when applicable) to obtain the higher reimbursement for the drug dispensed.

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14. COMMENT: N.J.A.C. 10:51-1.20: The commenter was concerned about drug efficacy review procedures established by the Federal Food and Drug Administration (FDA). The commenter requested that the Division provide pharmacies with advance notice of the list of "DESI drugs," as these drugs are referred to, from the Federal Register.

RESPONSE: The agency response is to add clarifying language that reinforces a longstanding Medicaid policy that there can be no payment for a "DESI drug," that is, one that is classified by the FDA as less than effective. Also, the Division has historically issued newsletters to pharmacy providers containing updates to the DESI list. The agency believes that the longstanding policy of not paying for DESI drugs pursuant to Federal regulations (21 C.F.R. 310.6) is appropriate. The commenter was not questioning the policy but was requesting an updated list of the non-covered drugs. The list of DESI drugs, and changes thereto, are published periodically in the Federal Register. This list is the official notice to all pharmacists of drugs that are not covered by the Medicaid programs. The agency has no discretion with regard to DESI drugs.

15. COMMENT: The commenter was concerned about the tape-to-tape incentive program and recommended the phrase "electronic media claims (EMC)" be substituted as more appropriate.

RESPONSE: The agency concurs. Multiple media are now available for electronic claims submission. Thus, the agency has made the change as requested by the commenter.

16. COMMENT: N.J.A.C. 10:51-3.4(a)5 and 6: The commenter noticed two words that needed to be changed.

RESPONSE: The agency's response is that the commenter was correct. The word "reverse" is being corrected to read "adverse" (N.J.A.C. 10:51-3.4(a)5) and the word "regiment" is being corrected to read "regimen" (N.J.A.C. 10:51-3.4(a)6).

17. COMMENT: N.J.A.C. 10:51-3: The commenter requested a reimbursement section for consultant pharmacy services.

RESPONSE: The agency's response is that pharmacy consultant services administered to nursing facility (NF) recipients are reimbursed by an NF under contractual agreement with the consultant pharmacist. the Division does not believe a reimbursement section is necessary since the Division does not directly reimburse consultant pharmacists.

18. The following issues pertain to the PAAD subchapter N.J.A.C. 10:51-4.

a. COMMENT: N.J.A.C. 10:51-4.1: The commenter requested a change to indicate that eligibility for PAAD is based upon income rather than "significant needs."

RESPONSE: The agency had already mentioned the income requirements in the introduction. The agency also amends the text to delete the word "significant" and add the word "medical" to reflect the type of needs satisfied by prescription drugs.

b. COMMENT: N.J.A.C. 10:51-4.16(d): The commenter requested the deletion of a handwritten "brand medically necessary" to prevent generic drug interchange in the PAAD program.

RESPONSE: This policy is not currently applicable to the PAAD program and shall be deleted from the text upon adoption.

c. COMMENT: N.J.A.C. 10:51-4.19: The commenter requested that under the Prescription Drug Price and Quality Stabilization Act, the law requires the patient to pay the difference between the brand product and the generic product when the prescriber does not permit brand interchange. The commenter requested this language be added to the text of the rule.

RESPONSE: The agency has revised the language at N.J.A.C. 10:51-4.19(a)3 to indicate that the State law cited in the proposed rule indicating that when a prescriber orders a drug by its generic name, the pharmacist shall dispense the least expensive, therapeutically effective product available at the time of dispensing. The product is not required to be from the list of interchangeable products.

Also, there is additional language being added at N.J.A.C. 10:51-4.19(a)4 to indicate if the prescriber does not indicate that substitution is not permissible, the PAAD program shall reimburse the pharmacy the maximum cost of the interchangeable drug product less the PAAD co-payment. The PAAD beneficiary can accept the interchangeable drug product or pay the difference and purchase the drug product which is higher in cost.

The agency believes this requirement does not impose any additional burden on either the pharmacist or beneficiary because this is a requirement under State law which the agency has to follow. In addition, the beneficiary is allowed to receive the drug, and the pharmacist will be reimbursed by the PAAD program in accordance with the policy.

This provision does not apply if the prescriber orders by generic name. The pharmacist can dispense the medication and will be reimbursed by the PAAD program.

19. COMMENT: I. Barton Frenchman, R.P., F.A.S.C.P., Pharmacist Rx Consultants, Inc., objected to the additional qualification for a consultant pharmacist in N.J.A.C. 10:51-3.3(a)2. The commenter's objection was that "this requirement sets up a specialty of consultant pharmacy contrary to the New Jersey Board of Pharmacy and puts its regulation in the hands of a private organization . . ."

RESPONSE: The agency's response is to delete this requirement since the only requirement for consultant pharmacists is licensure under Federal regulations 42 C.F.R. 483.60. The additional certification was determined not to be necessary.

The deletion of the proposed requirement should be less burdensome on pharmacists since they can qualify as consultant pharmacists on their licensure alone which conforms with the Federal Medicaid standard. The agency also received letters from Jesse M. Gaynor, R.Ph., Executive Director of the Joint Board for Certification of Consultant Pharmacists and from Harlan Martin, R.Ph., Pharma-Care, Inc. objecting to some of the statements contained in I. Barton Frenchman's letter. While both letters were received after the comment period, both Mr. Gaynor and Mr. Martin wished to rebut some of the contents of Mr. Frenchman's comment. Beyond the change already noted, the agency does not believe that the full "debate" is relevant to the primary issue of certification for consultant pharmacists.

20. COMMENT: David A. Banta, Pharmaceutical Manufacturers Association, questioned the use of the words "Brand Medically Necessary" to override generic substitution of MAC drugs in the PAAD program.

RESPONSE: The Division intends to delete the language for the reasons indicated in the response to Comment No. 13 above.

Summary of Changes Between Proposal and Adoption

The Division is making the following changes upon adoption. In those instances where the changes are the same, each subchapter has been listed and one explanation is provided.

N.J.A.C. 10:51-1.6(b)6ii, 2.6(b)6ii and 4.6(b)6ii:

The Division has added a provision indicating that for pharmacies with a total prescription volume of 50,000 prescriptions per year or greater, completion of a portion of the FD-70 is optional. This change was made in response to public comments (See Comment 3 above).

N.J.A.C. 10:51-1.8(b)2i: Language is being added in response to public comments that non-legend ingredients contained in compound prescriptions are covered for Medicaid recipients participating in the Garden State Health Plan. (See Comment 5 above.)

N.J.A.C. 10:51-1.12(a)1, 2.11(a)1 and 4.13(a)1: This is a technical deletion of the parenthesis so that the text clearly indicates the specific Federal statutory authority in part of the rule. (See Comment 7 above.)

N.J.A.C. 10:51-1.12(a)17, 2.11(a)16 and 4.13(a)14: The Division is adding text to the list of non-covered services to be certain that the longstanding policy of non-payment for preventive vaccines, biological and therapeutic drugs distributed to Medicaid providers free of charge can not be billed to the New Jersey Medicaid Program. The Division's policy of non-payment for preventive vaccines, biologicals and therapeutic drugs available free of charge was originally codified at N.J.A.C. 10:51, Appendix A, but this Appendix is being repealed with this adoption. The Division believes there is no additional burden placed upon pharmaceutical providers because there is no change in Division policy. In addition, there is general language in N.J.A.C. 10:49-5.4(a)2, the Administrative Chapter, which specifies that services provided "without charge" (to a Medicaid recipient) shall not be billed to the Medicaid Program.

The text of **N.J.A.C. 10:51-1.12(b)3** is being deleted upon adoption. The reason for this deletion is that on July 1, 1991 the State reduced coverage of non-legend drugs to include only antacids, insulin, insulin needles and syringes, diabetic testing materials and family planning items (see 23 N.J.R. 1310(b) and 2035(a)). This change in coverage minimizes significantly a need for the State to evaluate criteria establishing cost effectiveness for non-legend drugs. In addition, the accuracy of diabetic testing devices/supplies available in today's market has significantly improved, reducing a required evaluation by the Division to determine eligibility for payment based on the criteria formerly described in N.J.A.C. 10:51-1.12(b)3. Paragraph (b)4 (in the proposal) is being recodified as paragraph (b)3 in the adoption.

N.J.A.C. 10:51-1.13(a)1 is being amended to indicate the specific citation for an administrative emergency can be found in N.J.A.C.

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10:49-6.1(b)3 now that the Administration Chapter, N.J.A.C. 10:49 was adopted as R.1992, d.317, effective August 17, 1992.

N.J.A.C. 10:51-1.13(b)1ii is being added to indicate that prior authorization is removed for electrolyte replacement supplement. This change is less burdensome to both recipients and providers.

N.J.A.C. 10:51-1.13(b)5 is being rewritten to make a positive statement concerning prescriptions written by a physician or other health care practitioner authorized by law to prescribe as the result of a referral from GSHP physician case manager. In essence, if the referral provider writes the prescription, he or she must have approval from the GSHP physician case manager. (See Comment 12.)

N.J.A.C. 10:51-1.19(a)3 and 2.17(a)3 are being amended to indicate that when a prescriber authorizes the dispensing of a brand MAC drug, the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill Medicaid for the prescribed product. Similar requirements apply to PAAD beneficiaries. N.J.A.C. 10:51-4.19(a)5, which contains the same requirements, has been recodified from paragraph (a)3. (See Comment 13.)

N.J.A.C. 10:51-1.20(a)1iv, 2.18(a)2iv and 4.20(a)1iv are being amended in response to Comment 13 above. The clarifying language indicated it is the Federal Food and Drug Administration (FDA) that reviews the justification for a drug product's medical need. If a drug product fails this review, the product is classified as a DESI drug.

N.J.A.C. 10:51-1.23(a) and (c), 2.21(a) and (c), and 4.22(a) and (c) are being amended in response to Comment 15 above.

N.J.A.C. 10:51-1.5(a)2i, 2.5(a)2, and 4.5(a)2i are being added on adoption to provide additional information to pharmaceutical providers about the availability of current information contained on the New Jersey Medicaid Management Information System (NJMMIS) reference drug file. The additional text explains that the file is updated periodically by the fiscal agent based on data supplied by First Data Bank (FDB). The text also indicates that providers may utilize other sources, such as product literature distributed by drug manufacturers, various trade publications and other market information, to determine whether a product's therapeutic classification meet the criteria specified in N.J.A.C. 10:51-2.10.

The Division believes that this additional text provides clarification on the methods whereby pharmaceutical providers can obtain current information on covered drugs. There is no additional burden being placed on providers because the text explains the administrative process that is currently in effect. There is no change in the basis of payment for a covered drug.

In addition, providers are made aware of therapeutic indications for drugs by other means, including product literature, and various trade publications utilized as a normal and prudent business practice. The agency believes this clarifying language represents an accurate statement as to the means by which its drug file is updated and the availability of this information by industry sources. The objective is to ease the burden on pharmaceutical providers by recognizing that dissemination of the information can be via several sources.

N.J.A.C. 10:51-3.3 is being amended to delete the requirement for a consultant pharmacist certification. While there was a comment submitted by I. Barton Frenchman, R.P., the agency's primary reason is that licensure is the only standard required by Federal regulation.

N.J.A.C. 10:51-3.4(a)5 and 6 are being corrected in response to Comment 15 above.

N.J.A.C. 10:51-4.1 is being changed for the reason indicated in Comment 17 above. The agency also added a statement referring the reader to N.J.A.C. 10:69A for eligibility criteria.

N.J.A.C. 10:51-4.2(b)1: In response to the comment by the New Jersey Pharmaceutical Association, the Division has added this clarifying language to insure that the restriction on out-of-State pharmacies apply to both holders of retail and institution permits. PAAD is a completely State-funded pharmaceutical assistance program and this restriction on out-of-State pharmacies has been longstanding Division policy.

N.J.A.C. 10:51-4.6(b)8 is being amended to make text consistent with N.J.A.C. 10:51-1.6(b)8 and 2.6(b)8. The phrase "average wholesale price" needs to be inserted for the text to have any meaning.

N.J.A.C. 10:51-4.16(d) is being deleted upon adoption because the policy does not apply to the PAAD program. The use of "Brand Medically Necessary" is not required to override generic substitution of drugs in the PAAD program. This also pertains to David Banta's comment above.

N.J.A.C. 10:51-4.19(a)3 and 4 are being added to indicate the difference between PAAD and Medicaid. There is similarity between N.J.A.C. 10:51-1.19(a)3 and 2.17(a)3 with respect to the prescriber and pharmacist responsibility. The pharmacist is required to dispense the least expensive, therapeutically effective drug product at time of dispensing if a prescriber orders a drug by its generic name. The product does not have to be from the list of interchangeable products. The PAAD program shall reimburse the pharmacy for the estimated acquisition cost of the interchangeable product. This requirement does not apply if the prescriber has indicated substitution not permissible. However, the PAAD law allows a beneficiary to purchase the brand drug product (when a prescriber indicates that brand drug dispensing is not authorized) if a beneficiary wants to pay the differences, that is, additional cost of the drug.

N.J.A.C. 10:51-4.23(a) is being changed on adoption at the agency's initiative. State legislation (P.L. 1993, c.3) has established income eligibility levels commencing January 1, 1993 at $16,171 for a single person and $19,828 in combined income for a married couple.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 51
PHARMACEUTICAL SERVICES MANUAL

SUBCHAPTER 1. PHARMACEUTICAL SERVICES

10:51-1.1 Introduction

(a) This chapter provides information about the provision of pharmaceutical services under the New Jersey Medicaid program and the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program. It is divided into four subchapters:

1. N.J.A.C. 10:51-1 provides a pharmacy operating under a retail permit with the policies and procedures relevant to the provision of services to New Jersey Medicaid recipients, excluding those residing in a nursing facility.

2. N.J.A.C. 10:51-2 pertains to a pharmacy providing pharmaceutical services to Medicaid recipients in a nursing facility.

3. N.J.A.C. 10:51-3 explains the responsibility of a pharmacist acting as a consultant in a nursing facility or other public medical institution.

4. N.J.A.C. 10:51-4 provides information about the provision of pharmaceutical services under the PAAD program.

(b) Incorporated by reference into this chapter as Appendix D is the Fiscal Agent Billing Supplement that provides information about claim processing and related activities.

10:51-1.2 Participation of eligible providers

(a) A pharmacy, with a retail or institutional permit, may participate in the Medicaid program as a provider of pharmaceutical services; as a Medical Supplier providing medical supplies and durable medical equipment; and/or as a provider of parenteral nutrition and/or intravenous therapy. The requirements for approval as a provider of these services are listed in (b) through (d) below.

(b) To be approved as a provider of pharmaceutical services, the pharmacy must:

1. Operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey or by the board of pharmacy of the state in which the pharmacy is located. A pharmacy operating under an out-of-state institutional permit may not participate as an approved provider in the New Jersey Medicaid program; and

2. File an application and sign an agreement with the Division of Medical Assistance and Health Services.

i. Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. To execute a new agreement to participate in the New Jersey Medicaid program, the new owner(s) shall apply to the Division of Medical Assistance and Health Services, Department of Human Services, by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49—Administration Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

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3. To enroll as a Medicaid provider of pharmaceutical services, a pharmacy shall contact the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

(c) A pharmacy may also participate as a medical supplier. The Medical Supplier Manual, N.J.A.C. 10:59, available from the Medicaid fiscal agent, provides information concerning the provision of and reimbursement for covered medical supplies and durable medical equipment provided by a Medical supplier.

1. A pharmacy may apply to participate as a medical supplier by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49—Administrative Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

(d) Requirements for approval as a provider of parenteral nutrition and/or intravenous therapy are as follows:

1. In addition to the requirements for approval as a pharmacy provider listed under (b) above, a pharmacy who supplies parenteral nutrition and/or intravenous therapy must:

i. Comply with the requirements of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies; or

ii. Comply with similar applicable requirements of the state in which the applicant is located and submit a copy of the requirements of that state when applying for participation. A copy of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies, is available, subject to copying charges, from OAL Publications, Office of Administrative Law, CN 301, Trenton, New Jersey 08625.

2. Parenteral nutrition and/or intravenous therapy may be provided by either a pharmacy/medical supplier or a medical supplier approved to provide these services by the New Jersey Medicaid program; however, billing for the ancillary supplies associated with parenteral nutrition and/or intravenous therapy are subject to the requirements of the Medical Supplier Manual (N.J.A.C. 10:59).

i. "Ancillary supplies" means medical supplies and/or durable medical equipment which are medically necessary to facilitate administration of parenteral or intravenous therapy.

10:51-1.3 Conditions for participation as a provider of pharmaceutical services

(a) All participating pharmacies shall provide complete prescription services, including injectables and injectable anti-neoplastic agents, compounding, and prescription refill services, when allowable. Prescriptions must be dispensed in compliance with all current existing Federal and State laws.

(b) All drugs must be prescribed.

1. "Prescribed drugs" mean simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

i. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

(c) Participating pharmacies shall permit properly identified representatives of the Division of Medical Assistance and Health Services to:

1. Inspect written prescriptions on file;

2. Audit records pertaining to covered persons;

3. Inspect private sector records, where deemed necessary to comply with the Federal regulations to determine a pharmacy's usual and customary charge to the public;

i. Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

(1) Drug name;

(2) Quantity dispensed;

(3) Price;

(4) Prescription number (for reference purposes only); and

(5) Date dispensed;

ii. The pharmacy shall provide sufficient information with regard to its contractual agreement(s) and payment history with other private third party prescription plans to identify and verify number of claims, amount paid, and dispensing fee paid by group contracts within the plan. Records and contracts shall be available on-site at the time of audit; or available within 10 working days of an on-site audit. Records shall include, but not be limited to:

(1) Payment vouchers;

(2) Contracts; and

(3) Agreements; and

4. Inspect records of purchases of covered drugs for which claims have been made for reimbursement.

10:51-1.4 Program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in N.J.A.C. 10:51-1.11 and 10:51-1.12, respectively;

2. Pharmaceutical service requiring prior authorization (see N.J.A.C. 10:51-1.13);

3. Quantity of medication (see N.J.A.C. 10:51-1.14);

4. Dosage and directions (see N.J.A.C. 10:51-1.15);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-1.16);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51-1.17);

7. Prescription refill (see N.J.A.C. 10:51-1.18);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-1.19);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-1.9).

9. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-1.5, Basis of payment);

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-1.20 and listing of DESI drugs in Appendix A herein incorporated by reference); and

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration of the United States Department of Health and Human Services (see N.J.A.C. 10:51-1.21);

(b) A properly completed claim form must be submitted or a properly formatted electronic media claim (EMC) must be transmitted to the fiscal agent for claims processing.

1. The claim form may be completed manually or by computer, but only one prescription shall be billed on each claim form. See Appendix Fiscal Agent Billing Supplement for instructions concerning the completion and submission of the specified claim form;

2. All claim forms must contain the National Drug Code (NDC). The 11-digit NDC has three components. The first five digits are the manufacturer's labeler code, the next four digits are the product code, and the final two digits are the package size code. For claim submission, leading zeros must be included in all fields. For example, 00003-0234-01.

i. The Dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the actual stock package size used to fill the prescriptions.

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10:51-1.5 Basis of payment

(a) This section provides a summary of the elements involved in the calculation of the payment of a legend or non-legend drug. The elements include the following:

1. Program restrictions affecting reimbursement for the dispensing of drugs as listed in N.J.A.C. 10:51-1.4;

2. Price information as supplied from a reference drug file contracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The drug price or ingredient cost shall not exceed the lower of the average wholesale price as supplied by the reference drug file contractor; the provider's usual and customary charge; or the drug's maximum allowable cost, if applicable (see (b) below);

i. The NJMMIS reference drug file is updated periodically by the fiscal agent based upon data supplied by First Data Bank (FDB). The update process provides the fiscal agent with current data to include changes in product description. Providers are made aware of therapeutic indications for various classes of drugs by product literature distributed by drug manufacturers and by various trade publications. Based on market information, providers can determine whether a product's therapeutic classification meet the criteria specified in N.J.A.C. 10:51-1.11 (Covered Pharmaceutical Services).

3. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain covered drugs in the pharmaceutical program. The New Jersey Medicaid program refers to these upper limits as the "maximum allowable cost" (see (b) below); and

4. The provider's usual and customary charge for legend or non-legend drugs (see (c) below), contraceptive diaphragms and legend or non-legend devices.

(b) Payment for legend drugs is based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the Federal government or the average wholesale price (AWP). Appendix B is the listing of MAC drugs, and is hereby incorporated by reference.

1. Maximum allowable cost is defined as:

i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services;

ii. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements.

(1) Maximum cost for each eligible prescription claim not covered by (b)1i above is based on the lower of the AWP minus regression (discount) category, if applicable, plus dispensing fee, or usual and customary charge. For information about the "regression (discount) categories," see N.J.A.C. 10:51-1.6, and for usual and customary charge, see N.J.A.C. 10:51-1.10.

2. If the published MAC price as defined in (b)1i above is higher than the average wholesale price which would be paid as defined in (b)1ii above, then (b)1ii above shall apply.

(c) The maximum charge to the New Jersey Medicaid program for a legend drug, including the charge for the cost of medication and the dispensing fee, shall not exceed the lowest of the following:

1. Maximum allowable cost (MAC) as determined in (b)1 above, plus dispensing fee (see N.J.A.C. 10:51-1.7); or

2. The provider's usual and customary and/or posted or advertised charge.

(d) The maximum allowance for the non-legend drugs, devices, or supplies under the New Jersey Medicaid program is:

1. The product AWP plus 50 percent; or

2. The usual over-the-counter OTC retail price charged to the other persons in the community, whichever is less.

10:51-1.6 Regression (discount) categories

(a) The maximum cost for each eligible prescription claim not covered by the Maximum Allowable Cost price (see N.J.A.C. 10:51-1.5—Basis of Payment) is subject to the following fiscal conditions based upon six categories. The category, as determined by the New Jersey Medicaid program, is based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. Those pharmacy providers who have been in business for less than one calendar year shall have their prescription volume projected for the entire year, to determine the appropriate category.

(b) The pharmacy provider shall submit, in writing, an annual report on form FD-70 (See Appendix C, Pharmacy Provider Certification Statement) certifying its prescription volume. The Division shall determine a provider's total prescription volume, which includes all prescriptions filled (both new and refills), including nursing facility prescriptions, for private patients, Medicaid, PAAD, and other third party recipients for the previous calendar year. Failure to submit this report annually shall result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

1. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, as the maximum.

2. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less two percent, as the maximum.

3. Category III: Pharmacies whose total prescription volume in the preceding calendar year was at least 20,000 but not greater than 29,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less three percent, as the maximum.

4. Category IV: Pharmacies whose total prescription volume in the preceding calendar year was at least 30,000 but not greater than 39,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less four percent, as the maximum.

5. Category V: Pharmacies whose total prescription volume in the preceding calendar year was at least 40,000 but not greater than 49,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less five percent, as the maximum.

6. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less six percent, as the maximum.

ii. For pharmacies with a total prescription volume, in the preceding calendar year of 50,000 prescriptions or greater, completion of the portion of the FD-70 Certification Statement is optional. For these pharmacies, a maximum regression shall be automatically applied.

7. The appropriate calculated discount shall be automatically deducted, by the fiscal agent, from the cost of each covered drug or device during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

8. For covered drugs or devices with an average wholesale price (AWP) of more than $24.99, there shall be no discount from the AWP.

10:51-1.7 Prescription drug dispensing fee

(a) The dispensing fee for legend drugs, dispensed by providers having retail permits to recipients other than those in nursing

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facilities, is $3.73. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following:

1. Twenty-Four Hour Emergency Service: $0.11. The provider shall have a 24-hour per day, 365 days per year prescription service available and shall have provided Medicaid recipients opportunities to utilize this service.

2. Patient Consultation: $0.08. In addition to routinely monitoring recipient profiles for drug interactions, contraindications, allergies, etc., the provider shall, where appropriate, discuss the course of drug therapy with the recipient. This discussion must include emphasis on compliance with the prescriber's orders; proper drug utilization; cautions about possible side affects; foods to avoid; proper drug storage conditions; and any other information that will prove beneficial to the recipient while on drug therapy.

3. Impact Area Location: $0.15. The provider shall have a combined Medicaid and PAAD prescription volume equal to or greater than 50 percent of the provider's total prescription volume.

i. The nursing facility prescription volume shall be included for the determination of total prescription volume in determining entitlement to the impact allowance.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the New Jersey Medicaid program determines that the provider was not entitled to reimbursement for them.

10:51-1.8 Compounded prescriptions

(a) Compounded prescriptions extemporaneously prepared and dispensed by approved pharmacy providers are reimbursable by the Medicaid program as follows:

1. Total ingredient cost is defined in N.J.A.C. 10:51-1.5. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The dispensing fee is allowed in N.J.A.C. 10:51-1.7; plus

3. The maximum charge for a compounded prescription must not exceed the limits set forth in N.J.A.C. 10:51-1.14.

(b) Restriction in payments for compounded prescriptions are as follows:

1. All legend and non-legend (OTC) ingredients which are contained in compounded prescriptions must be covered by a manufacturer rebate agreement (see N.J.A.C. 10:51-1.21). If the labeler code of any single ingredient is not manufactured by an approved manufacturer, the compounded prescription is not covered. Chemical ingredients without NDC codes are excluded.

2. All non-legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a non-legend drug is not listed as covered in N.J.A.C. 10:51-1.11, the compounded prescription is not covered.

i. All non-legend ingredients contained in compounded prescriptions dispensed to eligible Garden State Health Plan (GSHP) participants are covered by the Medicaid program.

3. All legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a legend drug is a DESI (Drug Efficacy Study Implementation, see N.J.A.C. 10:51-1.20) drug, the compounded prescription is not covered.

4. Compounded prescriptions containing drugs not eligible for reimbursement under N.J.A.C. 10:51-1.12 are not covered.

10:51-1.9 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense the least expensive, therapeutically effective equivalent product available, preferably one listed in the DURC Formulary. The labeler code and drug product code of the actual product dispensed must be reported on the claim form. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-1.10 Provider's usual and customary charge or advertised charge

(a) The provider's usual and customary charge or advertised charge is an element considered in the calculation of the basis of payment for legend drugs (see N.J.A.C. 10:51-1.5, Basis of payment).

(b) The usual and customary charge to the Medicaid program is defined as the amount a provider charges the general public for a prescription for the same drug product (same NDC number) in the same quantity as the prescription being dispensed to a Medicaid recipient. "Usual and customary charge" means the actual charge made to the majority (51 percent) of the total patient population served by the individual pharmacy.

1. The provider shall not charge the Program more than would be charged to a cash customer when the general public, including private third party plans, accounts for more than 50 percent of a provider's total prescription volume.

i. In the event Medicaid and/or PAAD represent more than 50 percent of a provider's total prescription volume, then, for reimbursement purposes, the provider's usual and customary charge may be considered the amount the Program would reimburse for the same services.

10:51-1.11 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of the N.J.A.C. 10:49, Administration, and this chapter, and billed to the fiscal agent on the claim form or other approved billing method (see Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of the Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

2. Non-legend drugs, as follows, for which Federal Financial Participation (FFP) is available:

i. Contraceptive devices and contraceptive supplies (such as diaphragms, jellies, foams and condoms);

ii. Over-the-counter, family planning supplies (such as pregnancy test kits);

iii. Pharmaceutical inhalation devices;

iv. Diabetic testing materials;

v. Insulin needles and/or syringes;

vi. Insulin; and

vii. Antacids.

(c) For recipients in the Medically Needy component of the New Jersey Care . . . Special Medicaid programs, pharmaceutical services are only available to pregnant women and dependent children. For information on how to identify a Medicaid recipient, see N.J.A.C. 10:49, Administration.

10:51-1.12 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the New Jersey Medicaid program. For recipients in the Medically Needy component of the New Jersey Care . . . Special Medicaid programs, pharmaceutical services are not available to the aged, blind nor the disabled. For information on how to identify a covered person, see N.J.A.C. 10:49, Administration.

1. Prescriptions which are not for medically accepted indications *[(]*as defined in Section 1927(k)(6) of the Social Security Act*[)]*;

2. Antiobesics and anorexiants when used in treatment of obesity (see N.J.A.C. 10:51-1.13, Prior authorization);

3. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

4. Experimental drugs;

i. Exception: Drugs available only for treatment through an Investigational New Drug (IND) application shall be prior authorized;

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5. Medication furnished by a prescriber or an employee of a prescriber;

6. Medication prescribed for hospital inpatients;

7. Non-legend drugs other than antacids; contraceptive devices and contraceptive supplies; diabetic testing materials; over-the-counter (OTC) family planning supplies; inhalation devices (pharmaceutical); insulin; and insulin needles and/or syringes;

i. Exception: Antihistamines, antacids, OTC analgesics, laxatives, anti-diarrheal medications, OTC dermatological preparations, cold and cough medications, insulin, diabetic testing materials, family planning supplies and protein replacement supplements are services covered by the Garden State Health Plan;

8. Prescriptions written and/or dispensed with nonspecific directions;

9. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powdered diets used in the treatment of obesity;

i. Exception: Enteral nutritional products and electrolyte replacement supplements;

10. Methadone in any form (tablets, capsules, liquid, injectables, or powder) when used for drug detoxification or addiction maintenance (see N.J.A.C. 10:51-1.13, Prior authorization);

11. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

12. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

13. Radiopaque contrast materials (for example, Telepaque);

14. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51-1.20); and

ii. Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act (see N.J.A.C. 10:51-1.21);

15. Any bundled drug service (see N.J.A.C. 10:51-1.22); *[and]*

16. If the provider has a delivery service, he or she may waive or discount delivery charges to the recipient but is prohibited from charging more than his or her usual customary charge to the general public for delivery*[.]***; and***

17. Preventive vaccines, biologicals and therapeutic drugs distributed to hospital clinics and/or community health centers by the New Jersey Department of Health.

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51-1.5, Basis of payment;

2. Drug products in dosage forms whose labeling, prescription or promotional material indicate the primary use is cosmetic in nature; for example, hair restoration; ***and***

*[3. Covered non-legend drug products, devices and diabetic testing materials which do not offer significant price and/or therapeutic advantage. In the case of diabetic testing materials, the criteria shall be cost and improvement in accuracy over existing reimbursable products. Therapeutic advantage (in the case of diabetic testing materials, improvement in accuracy) shall be determined by evaluation of literature and/or cost effectiveness data submitted in support of a request for admission of a non-legend product for inclusion in the list of reimbursable products;

i. Manufacturers and distributors may request the review of a denial of reimbursement for products under this subsection by providing supportive information not previously submitted, within 30 days of the date of the denial. Agency decision after review of support material is final; and]*

*[4.]***3.*** Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting.

i. Exception: Drug products available only in a unit-dose package are covered.

(c) Reimbursement shall not be made for any claim submitted by a provider which involves a recipient restricted to another pharmacy, except for an emergency situation (see N.J.A.C. 10:49, Administration).

10:51-1.13 Services requiring prior authorization

(a) The provider shall obtain prior authorization, when required, by phone or in writing, from the Medicaid District Office (MDO) professional staff. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement. Information on the form is transmitted, on-line, from the MDO to the fiscal agent who, in turn, confirms the status of the authorization request by mail and provides the specific prior authorization number.

1. In an administrative emergency (see N.J.A.C. *[10:49, Administration,]* ***10:49-6.1(b)3***) when the MDO is unavailable, the provider may dispense a 72 hour supply of the prescribed drug.

i. If the drug is to be continued beyond 72 hours, ***and the MDO is unavailable, the provider may dispense a total of a five days' supply. If the drug is to be continued either beyond the 72 hours or five days period,*** the provider shall hold the claim and obtain prior authorization for the balance of the prescription when the MDO is available during normal business hours.

(b) The following drugs and specific therapeutic classes require prior authorization:

1. Enteral nutritional products and special infant formulas may only be authorized when medically necessary and when not available from the Women, Infant and Children (WIC) Nutritional program;

i. Medically necessary enteral nutritional products for treatment of recipients, which may be administered orally, via nasogastric tube, gastrostomy tube or needle catheter jejunostomy must be prior authorized. Special liquid or powdered diets for treatment of obesity or regular infant formulas are not considered enteral nutritional products;

ii. Electrolyte replacement supplements are not considered enteral nutritional supplements and do not require prior authorization.

2. Methadone (not eligible for reimbursement when used for drug detoxification or for addiction maintenance);

3. Drugs available only for treatment through an Investigational New Drug (IND) application shall be prior authorized;

4. Anorexiants and antiobesics when used for treatment of conditions approved by New Jersey State Board of Medical Examiners at N.J.A.C. 13:35-6.7; and

5. *[Those legend and non-legend drugs or devices which are not prescribed by the Garden State Health Plan Physician Case Managers (PCMs).]* ***Those legend and non-legend drugs or devices prescribed by physicians or other health care practitioners authorized by law to prescribe, as the result of a referral from a Garden State Health Plan Physician Case Manager (GSHP-PCM).***

10:51-1.14 Quantity of medication

(a) The quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or an amount sufficient to cover the interval between visits to the prescriber, but may not exceed a 60-day supply or 100 unit doses, whichever is greater. Any medication used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered a sustaining drug or maintenance medication and shall be prescribed in sufficient quantities to treat the recipient for at least 60 days or in 100 unit doses, whichever is greater. The pharmacist shall dispense the full quantity prescribed, within Program limits. Prescriptions shall not be split or reduced in quantity, unless the quantity prescribed exceeds Program limits, in which case the quantity shall be reduced to meet these limitations.

1. Exceptions:

i. Oral contraceptives may be prescribed and dispensed up to a supply of three ovulatory cycles; and

ii. When the full quantity prescribed (within Program limits) is not available at the time of dispensing, the pharmacist may dispense the quantity available and inform the Medicaid recipient accordingly. The pharmacist shall retain the claim form until the balance of the medication is dispensed.

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10:51-1.15 Dosage and directions

(a) Dosage and directions for use shall be indicated on all prescriptions. Prescriptions written and dispensed with no specific directions, such as "prn," "as directed" or "ad lib," etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

1. Exceptions:

i. Topical preparations including ophthalmic and otic drops and ointments;

ii. Aerosol inhalers; and

iii. Nitroglycerin.

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, shall be entered in the "Days Supply" filed on the pharmacy claim form.

(b) Dosage for the medications, under (a)1 above, cannot be related to the number of days supply. The pharmacist shall enter a value of "1" in the "Days Supply" filed on the pharmacy claim form.

10:51-1.16 Telephone-rendered original prescriptions

(a) Telephone orders from prescribers for original prescriptions shall be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, telephone authorization to refill an original prescription with no refill remaining is considered a new order and requires a new written prescription with a new prescription number. Stamping or writing a new number on the original prescription order does not constitute a new prescription under the Medicaid program.

(c) When a prescriber chooses not to allow product interchange on a telephone order, the statement "Substitution not permitted by prescriber-telephone Rx" plus the pharmacist's full signature next to or below the statement, shall appear on the prescription order. A rubber stamp bearing the statement is acceptable.

(d) When a prescriber chooses to certify "Brand Medically Necessary" on a telephoned prescription for a product included on the Federal MAC list, a written signed prescription order containing the certification, shall be sent to the pharmacist within seven days of the date of the telephone order. The written prescription shall be retained by the pharmacist as the original prescription. Failure to comply will result in the payment for that prescription being reduced to the MAC reimbursement level.

10:51-1.17 Changes or additions to the original prescription

Changes or additions to the original prescription, when approved by the prescriber, shall be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (for example, dosage, quantity, number of refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

10:51-1.18 Prescription refill

(a) The provider shall submit a properly completed claim form to the fiscal agent for reimbursement of an allowable refill. An allowable refill shall comply with the following instuctions in order to be reimbursed as such:

1. Refill instructions must be indicated in writing by the prescriber on the original prescription or verbally when telephoning the original prescription to the pharmacist. Verbal instructions shall be reduced to writing by the pharmacist, in accordance with N.J.S.A. 45:14-14.

2. When the prescriber indicates a prescription refill(s) on the original prescription, the number of refills are limited to a maximum of five refills within a six month period.

3. Exception: Oral contraceptives originally prescribed for three ovulatory cycles may be refilled up to three times within one year if so indicated by the prescriber on the original prescription.

4. Refill instructions indicating "refill prn" or indicating more than five refills, shall be subject to the limits imposed in (a)2 above, and shall be reimbursed up to these limits only.

5. A telephone authorized refill for a prescription with no refill remaining must be assigned a new prescription number.

6. Prescription refills shall not be dispensed until a reasonable quantity (approximately 75 percent) of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's written directions for use.

i. Exception: When a prescription is lost or destroyed, requiring a replacement prescription to be dispensed before the original prescription could have been consumed in accordance with the prescriber's written directions for use, the replacement prescription must be a new prescription with a unique prescription number.

10:51-1.19 Prescription Drug Price and Quality Stabilization Act

(a) The Prescription Drug Price and Quality Stabilization Act, N.J.S.A. 24:6E-1 et seq., shall apply to the New Jersey Medicaid program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial "Substitution Permissible" or the "Do Not Substitute" statement on a prescription for a drug product listed in the DURC Formulary, the pharmacist shall substitute from the list of interchangeable products and bill Medicaid accordingly.

2. When the prescriber initials "Substitution Permissible," the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed in the DURC Formulary as interchangeable with the brand name prescribed. The Medicaid recipient must accept the interchangeable product unless the recipient is willing to pay the pharmacy's full, usual and customary price. If that occcurs, the pharmacist shall so note on the prescription blank and no claim shall be submitted to Medicaid.

3. For non-MAC drugs (see N.J.A.C. 10:51-1.5), when the prescriber initials "Do Not Substitute," the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill Medicaid for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-1.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D, Fiscal Agent Billing Supplement for instructions about the claim form.)

4. When the prescriber orders by the generic name, the DURC Formulary (see N.J.A.C. 10:51-1.4) does not apply. The pharamacist shall dispense the least expensive, therapeutically effective product available to him or her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(b) Federal regulations prescribe the aggregate upper limit, for which Federal Financial Participation (FFP) is available, that Medicaid may reimburse for certain multi-source drugs. The limit shall apply to all listed MAC drugs (see Appendix B) unless the prescriber indicates in his or her own handwriting on each written prescription or follow-up written prescription to a telephone rendered prescription (see N.J.A.C. 10:51-1.9) the phrase "Brand Medically Necessary." The Federal regulation requires a handwritten statement and does not permit the use of alternatives such as a check-off box, initials or prescriber's signature, next to a preprinted statement "Do Not Substitute," nor does it allow a handwritten statement "Do Not Substitute." For purposes of reimbursement, the physician's override capability under N.J.S.A. 24:6E-1 does not apply to drugs which have a Federal MAC limit.

(c) Blanket authorization denying substitutions shall not be permitted. Each prescription order shall state "Brand Medically Necessary" in the prescriber's own handwriting. For non-MAC drugs, each prescription order shall follow the requirements of N.J.S.A. 24:6E-1 et seq. (see (a) above).

(d) The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-1.20 Drug Efficacy Study Implementation (DESI)

(a) "Less than effective drugs" are subject to a Notice of Opportunity for Hearing (NOOH) by the Food and Drug Administration (FDA).

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1. Reimbursement is not available for the purchase or administration of any drug product that meets all of the following conditions:

i. The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962;

ii. The drug product is available only through prescription;

iii. The drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the Federal Register on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications; and

iv. The drug product is at present *[not subject to a determination by FDA, made under its]* ***the subject of an*** efficacy review study ***performed by FDA*** (see 21 CFR 310.6 including all subsequent amendments and supplements*).* *[, for an explanation of this program), indicating there is a compelling justification of the drug product's medical need.]* ***The FDA efficacy review potentially can determine justification for a drug product's medical need. If a drug product fails this review, the product is classified as a DESI drug.***

2. Reimbursement is not available for the purchase or administration of any drug product that is identical, related or similar, as defined in 21 CFR 310.6 (including all subsequent amendments and supplements), to a drug product that meets the conditions of (a) above.

3. The initial list of drugs and related drug products classified as "less than effective" by the FDA pending outcome of the NOOH appears at 21 CFR 310.6. Subsequent revisions to this list which are adopted, shall appear in the Federal Register.

10:51-1.21 Drug manufacturers' rebate agreement

(a) In order for legend drug products to be reimbursed by the New Jersey Medicaid program, manufacturers must have in effect a rebate agreement pursuant to Section 4401 of OBRA 1990 and Section 1927 et seq. of the Social Security Act.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

10:51-1.22 Bundled drug service

(a) "Bundled drug service" means a drug or service that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

(b) Bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid program.

1. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

2. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

i. Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug by someone who has been receiving a bundled drug would result in the deprivation of the life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

ii. Those instances where use of the bundled drug has shown marked improvement in the recipient's clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

(c) In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625-0712.

1. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients shall receive or continue to receive the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services. Mail all the information to:

Medical Director
Division of Medical Assistance and
Health Services
CN 712
Trenton, NJ 08625-0712

10:51-1.23 *[Tape-to-tape incentive program]* ***Electronic Media Claims (EMC) Incentive Program***

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit Medicaid claims *[on magnetic tape]* ***electronically***. Incentive payments shall be made when the total volume of paid *[magnetic tape]* ***electronic media*** Medicaid/PAAD claims, submitted by pharmacy providers as a whole, equals or exceeds 20 percent of the total volume of paid Medicaid/PAAD claims.

(b) The reimbursement for incentive payments is based on the following schedule:

"Percent of Total Medicaid/PAAD Paid Claims"	"Amount of Incentive Payment"
20-29 percent	two cents/tape claim
30-39 percent	three cents/tape claim
40-55 percent	four cents/tape claim
over 55 percent	five cents/tape claim

(c) Claims volume figures shall be reviewed and averaged quarterly. The claim volume totals for the previous quarter shall determine the amount of incentive for the subsequent quarter. If the volume of paid tape claims is less than 20 percent of the total, no incentive payments shall be made. A pharmacy provider shall be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches 20 percent of the total paid claims volume. A qualified *[tape-to-tape pharmacy provider]* ***EMC submitter*** shall receive *[a separate incentive payment check for all tape]* ***payment on their Remittance Advice (RA) Statement for all electronic*** claims paid during the preceding month.

1. Incentive payment for a voided claim(s) shall be deducted from the subsequent month's total incentive payment, which follows the month in which the claim(s) was voided.

(d) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

(e) In order to be eligible to submit magnetic tape claims for the Medicaid and/or PAAD programs, a pharmacy provider shall complete the "New Jersey Medicaid Provider Electronic Billing Agreement," submit the completed agreement to the fiscal agent, and receive approval by the Division of Medical Assistance and Health Services.

SUBCHAPTER 2. PHARMACEUTICAL SERVICES TO MEDICAID RECIPIENTS IN A NURSING FACILITY

10:51-2.1 Introduction

This subchapter of the Manual provides information about the provision of reimbursable pharmaceutical services provided to Medicaid recipients in Medicaid approved nursing facilities.

10:51-2.2 Participation of eligible providers

(a) A pharmacy, with a retail or institutional permit, may participate in the Medicaid program as a provider of pharmaceutical services, and as a provider of parenteral nutrition or intravenous

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therapy. The requirements for approval as a provider of pharmaceutical services are listed in (b) and (c) below.

(b) To be approved as a provider of pharmaceutical services, the pharmacy must:

1. Operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey or by the board of pharmacy of the state in which the pharmacy is located. A pharmacy operating under an out-of-State institutional permit may not participate as an approved provider in the New Jersey Medicaid program; and

2. File an application and sign an agreement with the Division of Medical Assistance and Health Services.

i. Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. To execute a new agreement to participate in the New Jersey Medicaid program, the new owner(s) shall apply to the Division of Medical Assistance and Health Services, Department of Human Services, by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49—Administration Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

3. To enroll as a Medicaid provider of pharmaceutical services, a pharmacy shall contact the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

(c) Requirements for approval as a provider of parenteral nutrition and/or intravenous therapy are as follows:

1. In addition to the requirements for approval as a pharmacy provider listed under (b) above, a pharmacy who supplies parenteral nutrition and/or intravenous therapy must:

i. Comply with the requirements of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies; or

ii. Comply with similar applicable requirements of the state in which the applicant is located and submit a copy of the requirements of that state when applying for participation. A copy of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies, is available, subject to copying charges, from OAL Publications, Office of Administrative Law, CN 301, Trenton, New Jersey 08625.

2. Parenteral nutrition and/or intravenous therapy may be provided by either a pharmacy/medical supplier or a medical supplier approved to provide these services by the New Jersey Medicaid program; however, billing for the ancillary supplies associated with parenteral nutrition and/or intravenous therapy are subject to the requirements of the Medical Supplier Manual, N.J.A.C. 10:59.

i. "Ancillary supplies" means medical supplies and/or durable medical equipment which are medically necessary to facilitate administration of parenteral or intravenous therapy.

10:51-2.3 Conditions for participation as a provider of pharmaceutical services

(a) All participating pharmacies shall provide complete prescription services, including injectables and injectable anti-neoplastic agents and compounding services, when allowable. Prescriptions and in-patient medication orders must be dispensed in compliance with all current existing Federal and State laws.

(b) All drugs must be prescribed.

1. "Prescribed drugs" mean simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

i. Prescribed by a practitioner licensed or authorized by the state of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription and/or in-patient medication order that is recorded and maintained in the pharmacist's records.

(c) Participating pharmacies shall permit properly identified representatives of the Division of Medical Assistance and Health Services to:

1. Inspect written prescriptions and/or in-patient medication orders on file;

2. Audit records pertaining to covered persons;

3. Inspect private sector records, where deemed necessary to comply with the Federal regulations to determine a pharamacy's usual and customary charge to the public;

i. Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

(1) Drug name;

(2) Quantity dispensed;

(3) Price;

(4) Prescription number (for reference purposes only); and

(5) Date dispensed; and

4. Inspect records of purchases of covered drugs for which claims have been made for reimbursement.

10:51-2.4 Program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in N.J.A.C. 10:51-2.10 and 2.11, respectively;

2. Quantity of medication (see N.J.A.C. 10:51-2.12);

3. Dosage and directions (see N.J.A.C. 10:51-2.13);

4. Prescriptions and in-patient medication orders rendered by telephone or technological devices (see N.J.A.C. 10:51-2.14);

5. Changes or additions to the original prescription or in-patient medication order (see N.J.A.C. 10:51-2.15);

6. Prescription refill (see N.J.A.C. 10:51-2.16);

7. Prescription Drug price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-2.17);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-2.9);

8. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-2.5, Basis of payment);

9. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-2.18 and listing of DESI drug in Appendix A); and

10. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration of the United States Department of Health and Human Services (see N.J.A.C. 10:51-2.18).

(b) A properly completed claim form must be submitted or a properly formatted electronic media claim (EMC) must be transmitted to the fiscal agent for claims processing.

1. The claim form may be completed manually or by computer, but only one prescription shall be billed on each claim form. See Appendix, Fiscal Agent Billing Supplement for instructions concerning the completion and submission of the specified claim form. A dispensing fee is not reimbursed to providers providing pharmaceutical services to nursing facility recipients (see N.J.A.C. 10:51-2.7).

2. All claim forms must contain the National Drug Code (NDC). The 11-digit NDC has three components. The first five digits are the manufacturer's labeler code, the next four digits are the product code, and the final two digits are the package size code. For claim submission, leading zeros must be included in all fields, for example, 00003-0234-01.

i. The Dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the actual stock package size used to fill the prescriptions.

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10:51-2.5 Basis of payment

(a) This section provides a summary of the elements involved in the calculation of the payment of a legend or non-legend drug. The elements include the following:

1. Program restrictions affecting reimbursement for the dispensing of drugs as listed in N.J.A.C. 10:51-2.4;

2. Price information as supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The drug price or ingredient cost shall not exceed the lower of the average wholesale price as supplied by the reference drug file contractor; the provider's usual and customary charge; or the drug's Maximum Allowable Cost, if applicable (see (b) below);

i. The NJMMIS reference drug file is updated periodically by the fiscal agent based upon data supplied by First Data Bank (FDB). The update process provides the fiscal agent with current data to include changes in product description. Providers are made aware of therapeutic indications for various classes of drugs by product literature distributed by drug manufacturers and by various trade publications. Based on market information, providers can determine whether a product's therapeutic classification meet the criteria specified in N.J.A.C. 10:51-2.10 (Covered pharmaceutical services).

3. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain covered drugs in the pharmaceutical program. The New Jersey Medicaid program refers to these upper limits as the "maximum allowable cost" (see (b) below); and

4. The provider's usual and customary charge for legend drugs (see (c) below), contraceptive diaphragms and legend devices.

(b) Payment for legend drugs, contraceptive diaphragms, and reimbursable legend devices, is based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the federal government or the average wholesale price (AWP). See Appendix B for the listing of MAC drugs.

1. Maxium allowable cost is defined as:

i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services; or

ii. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements.

(1) Maximum cost for each eligible prescription claim not covered by (b)1i above is based on the lower of the AWP minus regression (discount) category, if applicable, plus dispensing fee. For information about the "regression (discount) categories," see N.J.A.C. 10:51-2.6.

2. If the published MAC price as defined in (b)1i above is higher than the average wholesale price which would be paid as defined in (b)1ii above, then (b)1ii above shall apply.

10:51-2.6 Regression (Discount) Categories

(a) The maximum cost for each eligible prescription claim not covered by the maximum allowable cost price (see N.J.A.C. 10:51-2.5—basis of payment) is subject to the following fiscal conditions based upon six categories. The category, as determined by the New Jersey Medicaid program, is based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. Those pharmacy providers who have been in business for less than one calendar year shall have their prescription volume projected for the entire year, to determine the appropriate category.

(b) The pharmacy provider shall submit, in writing, an annual report on form FD-70 (see Appendix C, Pharmacy Provider Certification Statement) certifying its prescription volume. The Division shall determine a provider's total prescription volume, which includes all prescriptions filled (both new and refills), including nursing facility prescriptions, for private patients, Medicaid, PAAD, and other third party recipients for the previous calendar year. Failure to submit this report annually shall result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

1. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5—as the maximum.

2. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less two percent, as the maximum.

3. Category III: Pharmacies whose total prescription volume in the preceding calendar year was at least 20,000 but not greater than 29,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less three percent, as the maximum.

4. Category IV: Pharmacies whose total prescription volume in the preceding calendar year was at least 30,000 but not greater than 39,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less four percent, as the maximum.

5. Category V: Pharmacies whose total prescription volume in the preceding calendar year was at least 40,000 but not greater than 49,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less five percent, as the maximum.

6. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less six percent, as the maximum.

ii. For pharmacies with a total prescription volume, in the preceding calendar year of 50,000 prescriptions or greater, completion of the portion of the FD-70 Certification Statement is optional. For these pharmacies a maximum regression shall be automatically applied.

7. The appropriate calculated discount shall be automatically deducted, by the fiscal agent, from the cost of each covered drug or device during the claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

8. For covered drugs or devices with an average wholesale price (AWP) of more than $24.99, there shall be no discount from the AWP.

10:51-2.7 Prescription Dispensing Fee (Capitation)

(a) The New Jersey Medicaid program capitates the dispensing fee for each prescription for recipients in Medicaid approved nursing facilities in accordance with the total number of Medicaid recipient days in the facility(ies) serviced by the pharmacy. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following levels of services:

Pharmacies with institutional permits shall be reimbursed as defined in (a) above, except that the daily per recipient capitation fee shall be 75 percent of the fee for pharmacies with retail permits.

1. Twenty-Four Hour Unit Dose Service: Pharmacies with retail permits dispensing medication in a dispensing system in which a 24-hour supply of unit dose oral medication, both solid (for example, tablets, capsules) and liquid formulations, is delivered for each

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recipient daily, shall be reimbursed the cost of all reimbursable legend medication plus a fee of $0.656 per recipient day.

i. Exception: Certain liquid medications that are supplied in concentrate form only and are administered by drop dosage cannot be supplied in a 24-hour dose.

2. Modified Unit Dose Service: Pharmacies with a retail permit dispensing medication in a dispensing system in which up to a one month supply of oral unit dose solid medication is delivered for each recipient (for example, unit dose solids, "bingo" card), shall be reimbursed the cost of all reimbursable legend medication plus a fee of $0.544 per recipient day.

3. Traditional Service: Pharmacies with a retail permit dispensing medication in a dispensing system in which a maximum one month supply of medication is delivered monthly for each recipient shall be reimbursed the cost of legend medication plus a fee of $0.487 per recipient day.

4. Computerized Service: Pharmacies which provide ancillary computerized services, such as, but not limited to, continuously updated computerized recipient profiles, clinical records (med sheets and physicians' orders on at least a monthly basis), etc., receive an added increment of $0.05 per recipient day, thereby making the total fee $0.706, $0.594 or $0.537 depending upon the dispensing system used.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System. The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the New Jersey Medicaid program determines that the provider was not entitled to reimbursement for them.

(d) When a nursing facility changes its servicing pharmacy provider, the new pharmacy provider must notify the fiscal agent so that the provider file of the New Jersey Medicaid Management Information System (NJMMIS) may be updated. The following information is required in writing:

1. A copy of the agreement between the servicing pharmacy provider and the nursing facility;

2. The provider number of the servicing pharmacy;

3. The effective date of the change in servicing pharmacy provider if not clearly indicated in the agreement between the servicing pharmacy provider and the nursing facility;

4. The name and address of the previous servicing pharmacy provider for the nursing facility;

5. The level of service to be provided (for example: traditional, modified unit dose, or 24-hour unit dose); and

6. A statement indicating the provision of ancillary computerized services or recordkeeping for the nursing facility.

10:51-2.8 Compounded prescriptions

(a) Compounded prescriptions extemporaneously prepared and dispensed by approved pharmacy providers are reimbursable by the Medicaid program as follows:

1. Total ingredient cost is defined in N.J.A.C. 10:51-2.5. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The maximum charge for a compounded prescription must not exceed the limits set forth in N.J.A.C. 10:51-2.12.

(b) Restrictions on payments for compounded prescriptions are as follows:

1. All legend and non-legend (OTC) ingredients which are contained in compounded prescriptions must be covered by a manufacturer rebate agreement (see N.J.A.C. 10:51-2.19). If the labeler code of any single ingredient is not manufactured by an approved manufacturer, the compounded prescription is not covered. Chemical ingredients without NDC codes are excluded.

2. All non-legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a non-legend drug is not listed as covered in N.J.A.C. 10:51-2.10, the compounded prescription is not covered.

3. All legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a legend drug is a DESI (Drug Efficacy Study Implementation, see N.J.A.C. 10:51-2.18) drug, the compounded prescription is not covered.

4. Compounded prescriptions containing drugs not eligible for reimbursement under N.J.A.C. 10:51-2.11 are not covered.

10:51-2.9 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense the least expensive, therapeutically effective equivalent product available, preferably one listed in the DURC Formulary. The labeler code and drug product code of the actual product dispensed must be reported on the claim form. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-2.10 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of N.J.A.C. 10:49 (Administration) and this Chapter, and billed to the fiscal agent on the claim form or other approved billing method. (See Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

10:51-2.11 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the New Jersey Medicaid program:

1. Prescriptions which are not for medically accepted indications *[(]*as defined in Section 1927(k)(6) of the Social Security Act*[)]*;

2. Antiobesics and anorexiants when used in treatment of obesity;

3. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

4. Experimental drugs;

i. Exception: Drugs available only for treatment through an Investigational New Drug (IND) application may be prior authorized;

5. Medication furnished by a prescriber or an employee of a prescriber;

6. Medication prescribed for hospital inpatients;

7. Non-legend drugs;

8. Prescriptions and in-patient medication orders written and/or dispensed with nonspecific directions;

9. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powdered diets used in the treatment of obesity;

10. Methadone in any form (tablets, capsules, liquid, injectables, or powder) when used for drug detoxification or addiction maintenance;

11. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

12. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

13. Radiopaque contrast materials (for example, Telepaque);

14. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51-2.18); and

ii. Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act (see N.J.A.C. 10:51-2.19); *[and]*

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15. Any bundled drug service (see N.J.A.C. 10:51-2.20)*[.]**; and*

16. Preventive vaccines, biologicals and therapeutic drugs distributed to hospital clinics and/or community health centers by the New Jersey Department of Health.

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51-2.5, basis of payment;

2. Drug products in dosage forms whose labeling, prescription or promotional material indicate the primary use is cosmetic in nature; for example, hair restoration; and

3. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting.

i. Exception: Drug products available only in a unit dose package are covered.

10:51-2.12 Quantity of medication

When the quantity of a drug or medication is not indicated in writing by the prescriber, the pharmacy provider shall dispense an appropriate quantity of medication not to exceed a one month supply (see N.J.A.C. 10:51-2.16, Prescription Refill).

10:51-2.13 Dosage and directions

(a) Dosage and directions for use shall be included as part of all prescriptions or in-patient medication orders. Prescriptions or inpatient medication orders written and dispensed with no specific directions, such as "prn," "as directed" or "ad lib," etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

1. Exceptions:

i. Topical preparations including ophthalmic and otic drops and ointments;

ii. Aerosol inhalers; and

iii. Nitroglycerin.

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, shall be entered in the "Days Supply" field on the pharmacy claim form.

(b) Dosage for the medications, under (a)1 above, cannot be related to number of days supply. The pharmacist shall enter a value of "1" in the "Days Supply" field on the pharmacy claim form.

10:51-2.14 Prescriptions and in-patient medication orders rendered by telephone or technological devices

(a) Telephone rendered and/or technologically transmitted (for example: Fax) original precriptions shall be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, a telephone rendered and/or a technologically transmitted (for example: Fax) authorization to refill an original prescription is considered a new prescription or in-patient medication order and requires a new prescription number. Stamping or writing a new number on the original prescription or in-patient medication order does not constitute a new prescription under the Medicaid program.

(c) When a prescriber chooses not to allow product interchange on a telephone rendered original prescription or in-patient medication order, the statement "Substitution not permitted by prescriber-telephoned Rx" plus the pharmacist's full signature next to or below the statement, shall appear on the medication order. A rubber stamp bearing the statement is acceptable.

(d) When a prescriber chooses to certify "Brand Medically Necessary" on a telephone rendered original prescription or in-patient medication order for a product included on the Federal MAC list, a written signed prescription or in-patient medication order containing the certification, shall be sent to the pharmacist within seven days of the date of the telephone order. The written in-patient medication order shall be retained by the pharmacist as the original prescription. Failure to comply will result in the payment for that prescription being reduced to the MAC reimbursement level.

10:51-2.15 Changes or additions to the original prescription or in-patient medication order

Changes or additions to the original prescription or in-patient medication order, when approved by the prescriber, shall be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (for example, dosage, quantity, number of refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

10:51-2.16 Prescription refill

(a) Refills are not allowed.

(b) For purposes of reimbursement, an order for continuation of medication shall be considered a new prescription requiring a new written prescription and new prescription number.

10:51-2.17 Prescription Drug Price and Quality Stabilization Act

(a) The Prescription Drug Price and Quality Stabilization Act, N.J.S.A. 24:6E-1 et seq., shall apply to the New Jersey Medicaid program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial "Substitution Permissible" or the "Do Not Substitute" statement on a prescription or in-patient medication order for a drug product listed in the DURC Formulary, the pharmacist shall substitute from the list of interchangeable products and bill Medicaid accordingly.

2. When the prescriber initials "Substitution Permissible" on the prescription blank, the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed in the DURC Formulary as interchangeable with the brand name prescribed. The Medicaid recipient must accept the interchangeable product unless the recipient is willing to pay the pharmacy's full, usual and customary price. If that occurs, the pharmacist shall so note on the prescription blank and no claim shall be submitted to Medicaid.

3. *[For non-MAC drugs (see N.J.A.C. 10:51-2.5), when the prescriber initials "Do Not Substitute" on the prescription blank, or writes "Do Not Substitute" on the in-patient medication order,]* ***When a prescriber authorizes, in accordance with (b) below, the dispensing of a brand MAC drug,*** the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill Medicaid for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-2.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D, Fiscal Agent Billing Supplement for instructions about the claim form).

4. When the prescriber orders by the generic name, the DURC Formulary (see N.J.A.C. 10:51-2.4) does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him or her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(b) Federal regulations prescribe the aggregate upper limits, for which Federal Financial Participation (FFP) is available, that Medicaid may reimburse for certain multi-source drugs. The limit shall apply to all listed MAC drugs (see Appendix B) unless the prescriber indicates in his or her own handwriting on each written prescription or in-patient medication order or follow-up written prescription or in-patient medication order to a telephone rendered prescription or technologically transmitted, (for example: Fax) (see N.J.A.C. 10:51-2.9) the phrase "Brand Medically Necessary." The Federal regulation requires a handwritten statement and does not permit the use of alternatives such as a check-off box, initials or prescriber's signature, next to a preprinted statement "Do Not Substitute," nor does it allow a handwritten statement "Do Not Substitute." For purposes of reimbursement, the physician's override capability under N.J.S.A. 24:6E-1 does not apply to drugs which have a Federal MAC limit.

(c) Blanket authorization denying substitutions shall not be permitted. Each prescription or in-patient medication order shall state "Brand Medically Necessary" in the prescriber's own handwrit-

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ing. For non-MAC drugs, each prescription order shall follow the requirements of N.J.S.A. 24:6E-1 et seq. (see (a) above).

(d) The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-2.18 Drug Efficacy Study Implementation (DESI)

(a) "Less than effective drugs" are subject to a Notice of Opportunity for Hearing (NOOH) by the Food and Drug Administration (FDA).

1. Reimbursement is not available for the purchase or administration of any drug product that meets all of the following conditions:

i. The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962;

ii. The drug product is available only through prescription;

iii. The drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the Federal Register on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications; and

iv. The drug product is at present *[not subject to a determination by FDA, made under its]* ***the subject of an*** efficacy review study ***performed by FDA*** (see 21 CFR 310.6 including all subsequent amendments and supplements***).*** *[, for an explanation of this program), indicating there is a compelling justification of the drug product's medical need.]* ***The FDA efficacy review potentially can determine justification for a drug product's medical need. If a drug product fails this review, the product is classified as a DESI drug.***

2. Reimbursement is not available for the purchase or administration of any drug product that is identical, related or similar, as defined in 21 CFR 310.6 (including all subsequent amendments and supplements), to a drug product that meets the conditions of (a) above.

3. The initial list of drugs and related drug products classified as "less than effective" by the FDA pending outcome of the NOOH appears at 21 CFR 310.6. Subsequent revisions to this list which are adopted, shall appear in the Federal Register.

10:51-2.19 Drug manufacturers' rebate agreement

(a) In order for legend drug products to be reimbursed by the New Jersey Medicaid program, manufacturers must have in effect a rebate agreement pursuant to Section 4401 of OBRA 1990 and Section 1927 et seq. of the Social Security Act.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

10:51-2.20 Bundled drug service

(a) "Bundled drug service" means a drug or service that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

(b) Bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid program.

1. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

2. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

i. Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug by someone who has been receiving a bundled drug would result in the deprivation of the life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

ii. Those instances where use of the bundled drug has shown marked improvement in the recipient's clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

(c) In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625-0712.

1. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients shall receive or continue to receive the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services. Mail all the information to:

Medical Director
Division of Medical Assistance and Health Services
CN 712
Trenton, NJ 08625-0712

10:51-2.21 *[Tape-to-tape incentive program]* ***Electronic Media Claims (EMC) Incentive Program***

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit Medicaid claims *[on magnetic tape]* ***electronically***. Incentive payments shall be made when the total volume of paid *[magnetic tape]* ***electronic media*** Medicaid/PAAD claims, submitted by pharmacy providers as a whole, equals or exceeds 20 percent of the total volume of paid Medicaid/PAAD claims.

(b) The reimbursement for incentive payments is based on the following schedule:

"Percent of total Medicaid/ PAAD Paid Claims"	"Amount of Incentive Payment"
20-29 percent	two cents/tape claim
30-39 percent	three cents/tape claim
40-55 percent	four cents/tape claim
over 55 percent	five cents/tape claim

(c) Claims volume figures shall be reviewed and averaged quarterly. The claim volume totals for the previous quarter shall determine the amount of incentive for the subsequent quarter. If the volume of paid tape claims is less than 20 percent of the total, no incentive payments shall be made. A pharmacy provider shall be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches 20 percent of the total paid claims volume. A qualified *[tape-to-tape pharmacy provider]* ***EMC submitter*** shall receive *[a separate incentive payment check for all tape]* ***payment on their Remittance Advice (RA) Statement for all electronic*** claims paid during the preceding month.

1. Incentive payment for a voided claim(s) shall be deducted from the subsequent month's total incentive payment, which follows the month in which the claim(s) was voided.

(d) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

(e) In order to be eligible to submit magnetic tape claims for the Medicaid and/or PAAD programs, a pharmacy provider shall complete the "New Jersey Medicaid Provider Electronic Billing Agreement," submit the completed agreement to the fiscal agent, and receive approval by the Division of Medical Assistance and Health Services.

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SUBCHAPTER 3. CONSULTANT PHARMACIST SERVICES

10:51-3.1 Introduction

All services required of a consultant pharmacist in nursing facilities (that is, a skilled nursing facility, an infirmary section of a home for the aged, or a public medical institution) as stipulated in Federal and State statutes, rules and regulations, including, but not limited to, those listed as this subchapter, shall be provided.

10:51-3.2 Definition of consultant pharmacist

The term "consultant pharmacist" shall mean a pharmacist licensed by the New Jersey State Board of Pharmacy, and who meets the qualifications in N.J.A.C. 10:51-3.3.

10:51-3.3 Qualifications

*[(a) Qualifications for a consultant pharmacist include the following:

1. Holding a valid license as a registered pharmacist from the New Jersey State Board of Pharmacy; and

2. Having received certification by the Joint Board for Certification of Consultant Pharmacists of New Jersey, or its equivalent. This requirement shall become effective (two years from the effective date of adoption of this rule).]* ***Qualifications shall include holding a valid license as a registered pharmacist issued by the New Jersey State Board of Pharmacy.***

10:51-3.4 Responsibilities

(a) The consultant pharmacist shall in cooperation and consultation with the nursing facility staff:

1. Assure that all drugs are dispensed, and in cooperation with the director of nursing, "shall assure all drugs" are administered in compliance with all Federal and State laws;

2. Establish and monitor the implementation of written policies and procedures, through the pharmaceutical services committee (pharmacy and therapeutics committee), to assure the safe use, storage, integrity, administration, control and accountability of drugs;

3. Assure that drug records are in order and an account of all controlled substances is maintained and reconciled;

4. Assure that the recipient's medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physicians' orders and established stop-order policies;

5. Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same recipient, are monitored for potential *[reverse]* ***adverse*** reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications, and that the physician is advised promptly of any recommended changes;

6. Review the drug *[regiment]* ***regimen*** (for example, dosage form, route of administration, time of administration) of each recipient at least monthly and report any irregularities pertaining to medications to the attending physician, medical director or director of nursing, as appropriate.

i. Irregularities in the administration of medications shall also be reported promptly to the director of nursing.

7. Report in writing at least quarterly to the pharmaceutical services committee (pharmacy and therapeutic committee) on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each recipient's drug regimen and clinical record and the consultant pharmacist's findings and recommendations;

8. Assure there is maintained and available upon request from the Director of the New Jersey Medicaid program or his or her designee, documented records of the disposition, disposal or destruction of unused or discontinued drugs;

9. Serve as an active member of the pharmaceutical services committee (pharmacy and therapeutics committee) and infection control committee of the facility;

10. Provide, and document, in-service programs for the complete nursing staff. This training shall include, but not be limited to, registered nurses, licensed practical nurses, aides, and shall be given at least quarterly; and

11. Devote a sufficient number of hours to carry out these responsibilities, maintain a written record of activities, findings and recommendations.

SUBCHAPTER 4. PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED PROGRAM (PAAD)

10:51-4.1 Introduction

This subchapter provides information about the provision of pharmaceutical services under the PAAD program which shall extend assistance to certain persons whose level of income disqualifies them for medical assistance under the Medical Assistance and Health Services Act, but who have *[significant]* ***medical*** needs for prescribed drugs and/or insulin, insulin needles, insulin syringes and diabetic testing materials and are unable to fully meet the cost of such items. ***For additional information regarding PAAD eligibility, see N.J.A.C. 10:69A.***

10:51-4.2 Participation of eligible providers

(a) A pharmacy, with a retail or institutional permit, may participate in the PAAD program as a provider of pharmaceutical services.

(b) To be approved as a provider of pharmaceutical services, the pharmacy must:

1. Operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey. A pharmacy operating under an out-of-State ***retail or*** institutional ***pharmacy*** permit may not participate as an approved provider in the PAAD program.

2. File an application and sign an agreement with the Division of Medical Assistance and Health Services.

i. Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. To execute a new agreement to participate in the PAAD program, the new owner(s) shall apply to the Division of Medical Assistance and Health Services, Department of Human Services, by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49, Administration Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit.

3. To enroll as a Medicaid provider of pharmaceutical services, a pharmacy shall contact the fiscal agent Provider Enrollment Unit (see Appendix D, Fiscal Agent Billing Supplement).

10:51-4.3 Conditions for participation as a provider of pharmaceutical services

(a) All participating pharmacies shall provide complete prescription services, including injectables and injectable anti-neoplastic agents, compounding, and prescription refill services, when allowable. Prescriptions must be dispensed in compliance with all current existing Federal and State laws.

(b) All drugs must be prescribed.

1. "Prescribed drugs" mean simple or compounded substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

i. Prescribed by a practitioner licensed or authorized by the state of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is recorded and maintained in the pharmacist's records.

(c) Participating pharmacies shall permit properly identified representatives of the Division of Medical Assistance and Health Services to:

1. Inspect written prescriptions on file;

2. Audit records pertaining to covered persons;

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3. Inspect private sector records, where deemed necessary to determine a pharmacy's ususal and customary charges to the public;

i. Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

(1) Drug name;

(2) Quantity dispensed;

(3) Price;

(4) Prescription number (for reference purposes only); and

(5) Date dispensed.

ii. The pharmacy shall provide sufficient information with regard to its contractual agreement(s) and payment history with other private third party prescription plans to identify and verify number of claims, amount paid, and dispensing fee paid by group contracts within the plan. Records and contracts shall be available on-site at the time of audit; or available within 10 working days of an on-site audit. Records shall include, but not be limited to:

(1) Payment vouchers;

(2) Contracts; and

(3) Agreements; and

4. Inspect records of purchases of covered drugs for which claims have been made for reimbursement.

10:51-4.4 Program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in N.J.A.C. 10:51-4.12 and 4.13, respectively;

2. Quantity of medication (see N.J.A.C. 10:51-4.14);

3. Dosage and directions (see N.J.A.C. 10:51-4.15);

4. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-4.16);

5. Changes or additions to the original prescription (see N.J.A.C. 10:51-4.17);

6. Prescription refill (see N.J.A.C. 10:51-4.18);

7. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-4.19);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-Proprietary or generic dispensing (see N.J.A.C. 10:51-4.9);

8. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-4.5, Basis of payment); and

9. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-4.20 and listing of DESI drugs in Appendix A).

(b) A properly completed claim form must be submitted or a properly formatted electronic media claim (EMC) must be transmitted to the fiscal agent for claims processing.

1. The claim form may be completed manually or by computer, but only one prescription shall be billed on each claim form. See Appendix Fiscal Agent Billing Supplement for instructions concerning the completion and submission of the specified claim form;

2. All claim forms must contain the National Drug Code (NDC). The 11 digit NDC has three components. The first five digits are the manufacturer's labeler code, the next four digits are the product size code, and the final two digits are the package code. For claim submission, leading zeros must be included in all fields, for example, 00003-0234-01.

i. The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the actual stock package size used to fill the prescriptions.

10:51-4.5 Basis of payment

(a) This section provides a summary of the elements involved in the calculation of the payment of legend or certain non-legend drugs. The elements include the following:

1. Program restrictions affecting reimbursement for the dispensing of drugs as listed in N.J.A.C. 10:51-4.4;

2. Price information as supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The drug price shall not exceed the lower of the average wholesale price as supplied by the reference drug file contractor; the provider's usual and customary charge; or the drug's maximum allowable cost, if applicable (see (b) below);

i. The NJMMIS reference drug file is updated periodically by the fiscal agent based upon data supplied by First Data Bank (FDB). The update process provides the fiscal agent with current data to include changes in product description. Providers are made aware of therapeutic indications for various classes of drugs by product literature distributed by drug manufacturers and by various trade publications. Based on market information, providers can determine whether a product's therapeutic classification meet the criteria specified in N.J.A.C. 10:51-4.12 (Covered pharmaceutical services).

3. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain covered drugs in the pharmaceutical program. The New Jersey Medicaid program refers to these upper limits as the "maximum allowable cost" (see (b) below); and

4. Provider's usual and customary charge for legend drugs (see (c) below), insulin, insulin needles and syringes, or diabetic testing materials.

(b) Payment for legend drugs is based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the Federal government or the average wholesale price (AWP). See Appendix B for the listing of MAC drugs.

1. Maximum allowable cost is defined as:

i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services or established by the Division of Medical Assistance and Health Services; or

ii. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements.

(1) Maximum cost for each eligible prescription claim not covered by (b)1i above is based on the lower of the AWP minus regression (discount) category, if applicable, plus dispensing fee, or usual and customary charge. For information about the "regression (discount) categories," see N.J.A.C. 10:51-4.6 and for usual and customary charge, see N.J.A.C. 10:51-4.11.

2. If the published MAC price as defined in (b)1i above is higher than the average wholesale price which would be paid as defined in (b)1ii above, then (b)1ii above shall apply.

(c) The maximum charge to the PAAD program for a legend drug, including the charge for the cost of medication and the dispensing fee, shall not exceed the lowest of the following:

1. Maximum allowable cost (MAC) as determined in (b)1 above, plus dispensing fee (see N.J.A.C. 10:51-4.7); or

2. The provider's usual and customary and/or posted or advertised charge.

(d) The maximum allowance for the non-legend drugs, devices, or supplies under the PAAD program is:

1. The product AWP plus 50 percent; or

2. The usual over-the-counter (OTC) retail price charged to the other persons in the community, whichever is less.

10:51-4.6 Regression (discount) categories

(a) The maximum cost for each eligible prescription claim not covered by the maximum allowable cost price (see N.J.A.C. 10:51-4.5

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Basis of payment) is subject to the following fiscal conditions based upon six categories. The category, as determined by the New Jersey Medicaid program, is based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. Those pharmacy providers who have been in business for less than one calendar year shall have their prescription volume projected for the entire year, to determine the appropriate category.

(b) The pharmacy provider shall submit, in writing, an annual report on form FD-70 (See Appendix C, Pharmacy Provider Certification Statement) certifying its prescription volume. The Division shall determine a provider's total prescription volume, which includes all prescriptions filled (both new and refills), including nursing facility prescriptions, for private patients, Medicaid, PAAD, and over third party recipients for the previous calendar year. Failure to submit this report annually shall result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

1. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5—basis of payment, as the maximum.

2. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less two percent, as the maximum.

3. Category III: Pharmacies whose total prescription volume in the preceding calendar year was at least 20,000 but not greater than 29,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less three percent, as the maximum.

4. Category IV: Pharmacies whose total prescription volume in the preceding calendar year was at least 30,000 but not greater than 39,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less four percent, as the maximum.

5. Category V: Pharmacies whose total prescription volume in the preceding calendar year was at least 40,000 but not greater than 49,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less five percent, as the maximum.

6. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less six percent, as the maximum.

ii. For pharmacies with a total prescription volume, in the preceding calendar year of 50,000 prescriptions or greater, completion of the portion of the FD-70 Certification Statement is optional. For these pharmacies a maximum regression shall be automatically applied.

7. The appropriate calculated discount shall be automatically deducted, by the fiscal agent, from the cost of each covered drug or device during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

8. For covered drugs or devices ***with an average wholesale price (AWP) of*** more than $24.99, there shall be no discount from the (AWP).

10:51-4.7 Prescription drug dispensing fee

(a) The dispensing fee for legend drugs, dispensed by providers having retail permits to recipients other than those in nursing facilities, is $3.73. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following:

1. Twenty-four hour emergency service: $0.11. The provider shall have a 24-hour per day, 365 days per year prescription service available and shall have provided PAAD beneficiaries opportunities to utilize this service.

2. Patient consultation: $0.08. In addition to routinely monitoring recipient profiles for drug interactions, contraindications, allergies, etc., the provider shall, where appropriate, discuss the course of drug therapy with the recipient. This discussion must include emphasis on compliance with the prescriber's orders; proper drug utilization; cautions about possible side affects; foods to avoid; proper drug storage conditions; and any other information that will prove beneficial to the recipient while on drug therapy.

3. Impact area location: $0.15. The provider shall have a combined Medicaid and PAAD prescription volume equal to or greater than 50 percent of the provider's total prescription volume.

i. The nursing facility prescription volume shall be included for the determination of total prescription volume in determining entitlement to the impact allowance.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the PAAD program determines that the provider was not entitled to reimbursement for them.

10:51-4.8 PAAD program copayment

(a) Beneficiaries in the PAAD program are responsible for a part of the cost of drugs and devices covered by the PAAD program. At the point of sale, a PAAD beneficiary shall render to a pharmacy provider a fixed or adjustable copayment of an amount determined appropriate by the Legislature.

(b) A copayment shall be rendered to a pharmacy provider for each original or refill prescription dispensed. The provider's usual and customary charge billed to the PAAD program shall be inclusive of the copayment amount which will be deducted by the New Jersey Medicaid Management Information System (NJMMIS).

1. Under no circumstances is the required rendered copayment amount to be waived for reasons of promotion, advertisement and/or competitive considerations. Failure to comply with PAAD program copayment requirements may result in a suspension of a provider's approval to participate in the PAAD program.

10:51-4.9 Compounded prescriptions

(a) Compounded prescriptions extemporaneously prepared and dispensed by approved pharmacy providers are reimbursable by the PAAD program as follows:

1. Total ingredient cost is defined in N.J.A.C. 10:51-4.5. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The dispensing fee is allowed in N.J.A.C. 10:51-4.7; plus

3. The maximum charge for a compounded prescription must not exceed the limits set forth in N.J.A.C. 10:51-4.14.

(b) Restrictions on payments for compounded prescriptions are as follows:

1. All legend ingredients which are contained in compounded prescriptions must be covered by the PAAD program. If a legend

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drug is a DESI (Drug Efficacy Study Implementation, see N.J.A.C. 10:51-4.20) drug, the compounded prescription is not covered.

2. Compounded prescriptions containing drugs not eligible for reimbursement under N.J.A.C. 10:51-4.13 are not covered.

10:51-4.10 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense the least expensive, therapeutically effective equivalent product available, preferably one listed in the DURC Formulary. The labeler code and drug product code of the actual product dispensed must be reported on the claim form. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-4.11 Provider's usual and customary charge or advertised charge

(a) The provider's usual and customary charge or advertised charge is an element considered in the calculation of the basis of payment for legend drugs (see N.J.A.C. 10:51-4.5, Basis of payment).

(b) The usual and customary charge to the PAAD program is defined as the amount a provider charges the general public for a prescription for the same drug product (same NDC number) in the same quantity as the prescription being dispensed to a PAAD beneficiary. "Usual and customary charge" means the actual charge made to the majority (51 percent) of the total patient population served by the individual pharmacy.

1. The provider shall not charge the Program more than would be charged to a cash customer when the general public, including private third party plans, accounts for more than 50 percent of a provider's total prescription volume.

i. In the event Medicaid and/or PAAD represent more than 50 percent of a provider's total prescription volume, then, for reimbursement purposes, the provider's usual and customary charge may be considered the amount the Program would reimburse for the same services.

10:51-4.12 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of N.J.A.C. 10:49, Administration, and this Chapter, and billed to the fiscal agent on the claim form or other approved billing method (see Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of the Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

2. Non-legend drugs, as follows:

i. Diabetic testing materials;

ii. Insulin needles and/or syringes; and

iii. Insulin.

10:51-4.13 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the PAAD program:

1. Prescriptions which are not for medically accepted indications *[(]*as defined in Section 1927(k)(6) of the Social Security Act*[)]*;

2. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

3. Experimental drugs;

4. Medication furnished by a prescriber or an employee of a prescriber;

5. Medication prescribed for hospital inpatients;

6. Non-legend drugs other than diabetic testing materials; insulin; and insulin needles and/or syringes;

7. Prescriptions written and/or dispensed with nonspecific directions;

8. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powered diets used in the treatment of obesity;

9. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

10. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

11. Radiopaque contrast materials (for example, Telepaque);

12. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51-4.20);

13. Any bundled drug service, except drug product cost which is a component of a bundled drug service (see N.J.A.C. 10:51-4.21); *[and]*

14. Preventive vaccines, biologicals and therapeutic drugs distributed to hospital clinics and/or community health centers by the New Jersey Department of Health; and

*[14.]***15.*** If the provider has a delivery service, he or she may waive or discount delivery charges to the recipient but is prohibited from charging more than his or her usual and customary charge to the general public for delivery.

(b) Otherwise reimbursement products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51-4.5, Basis of payment;

2. Covered diabetic testing materials which do not offer significant price and/or therapeutic advantage. The criteria shall be cost and improvement in accuracy over existing reimbursable products. Therapeutic advantage (in the case of diabetic testing materials improvement in accuracy) shall be determined by evaluation of literature and/or cost effectiveness data submitted in support of a request for admission of a diabetic testing material for inclusion in the list of reimbursable products; and

3. Manufacturers and distributors may request the review of a denial of reimbursement for products under this subsection by providing supportive information not previously submitted, within 30 days of the date of the denial. Agency decision after review of support material is final.

10:51-4.14 Quantity of medication

(a) The quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or an amount sufficient to cover the interval between visits to the prescriber, but may not exceed a 60-day supply or 100 unit doses, whichever is greater. Any medication used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered a sustaining drug or maintenance medication and shall be prescribed in sufficient quantities to treat the recipient for at least 60 days or in 100 unit doses, whichever is greater. The pharmacist shall dispense the full quantity prescribed, within Program limits. Prescriptions shall not be split or reduced in quantity, unless the quantity prescribed exceeds Program limits, in which case the quantity shall be reduced to meet these limitations.

1. Exceptions:

i. Oral contraceptives may be prescribed and dispensed up to a supply of three ovulatory cycles; and

ii. When the full quantity prescribed (within Program limits) is not available at the time of dispensing, the pharmacist may dispense the quantity available and inform the PAAD beneficiary accordingly. The pharmacist shall retain the claim form until the balance of the medication is dispensed.

10:51-4.15 Dosage and directions

(a) Dosage and directions for use shall be indicated on all prescriptions. Prescriptions written and dispensed with no specific directions, such as "prn," "as directed" or "ad lib," etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

1. Exceptions:

i. Topical preparations including ophthalmic and otic drops and ointments;

ii. Aerosol inhalers; and

iii. Nitroglycerin.

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use,

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shall be entered in the "Days Supply" field on the pharmacy claim form.

(b) Dosage for the medications, under (a)1 above, cannot be related to number of days supply. The pharmacist shall enter a value of "1" in the "Days Supply" field on the pharmacy claim form.

10:51-4.16 Telephone-rendered original prescriptions

(a) Telephone orders from prescribers for original prescriptions shall be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, telephone authorization to refill an original prescription with no refill remaining is considered a new order and requires a new written prescription with a new prescription number. Stamping or writing a new number on the original prescription order does not constitute a new prescription under the PAAD program.

(c) When a prescriber chooses not to allow product interchange on a telephone order, the statement "Substitution not permitted by prescriber-telephoned Rx" plus the pharmacist's full signature next to or below the statement, shall appear on the prescription order. A rubber stamp bearing the statement is acceptable.

[(d) When a prescriber chooses to certify "Brand Medically Necessary" on a telephoned prescription for a product included on the Federal MAC list, a written signed prescription order containing the certification shall be sent to the pharmacist within seven days of the date of the telephone order. The written prescription shall be retained by the pharmacist as the original prescription. Failure to comply shall result in the payment for that prescription being reduced to the MAC reimbursement level.]

10:51-4.17 Changes or additions to the original prescription

Changes or additions to the original prescription, when approved by the prescriber, shall be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (for example, dosage, quantity, number or refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

10:51-4.18 Prescription refill

(a) The provider shall submit a properly completed claim form to the fiscal agent for reimbursement of an allowable refill. An allowable refill shall comply with the following instructions in order to be reimbursed as such:

1. Refill instructions must be indicated in writing by the prescriber on the original prescription or verbally when telephoning the original prescription to the pharmacist. Verbal instructions shall be reduced to writing by the pharmacist, in accordance with N.J.S.A. 45:14-14.

2. The original prescription is valid for the twelve month period beginning with the date of the original prescription. There is no limit to the number of refills dispensed during the twelve month period.

3. Exception: Oral contraceptives originally prescribed for three ovulatory cycles may be refilled up to three times within one year if so indicated by the prescriber on the original prescription.

4. Refill instructions indicating "refill prn" or indicating more than five refills, shall be subject to the limits imposed in (a)2 above, and shall be reimbursed up to these limits only.

5. A telephone authorized refill for a prescription with no refill remaining must be assigned a new prescription number.

6. Prescription refills shall not be dispensed until a reasonable quantity (approximately 75 percent) of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's written directions for use.

i. Exception: When a prescription is lost or destroyed, requiring a replacement prescription to be dispensed before the original prescription could have been consumed in accordance with the prescriber's written directions for use, the replacement prescription must be a new prescription with a unique prescription number.

10:51-4.19 Prescription Drug Price and Quality Stabilization Act

(a) The Prescription Drug Price and Quality Stabilization Act, N.J.S.A. 24:6E-1 et seq., shall apply to the PAAD program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial "Substitution Permissible" or the "Do Not Substitute" statement on a prescription for a drug product listed in the DURC (reference here to where it is defined) Formulary, the pharmacist shall substitute from the list of interchangeable products and bill PAAD accordingly.

2. When the prescriber initials "Substitution Permissible," the pharmacist shall dispense and bill PAAD for one of the less expensive products listed in the DURC Formulary as interchangeable with the brand name prescribed.

*[3. For MAC drugs (see N.J.A.C. 10:51-4.5), when the prescriber initials "Do Not Substitute," the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill PAAD for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-4.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D, Fiscal Agent Billing Supplement for instructions about the claim form.)

4. When the prescriber orders by the generic name, the DURC Formulary (see N.J.A.C. 10:51-4.4) does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him or her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.]*

***3. When the prescriber orders by generic name, the formulary does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him/her at the time of dispensing. The product is not required to be from the list of interchangeable products.**

4. Whenever the prescriber does not specify that substitution is not permitted and an interchangeable drug product that is listed in the latest issue of the formulary is available for the prescription written, the PAAD program shall reimburse the pharmacy only for the maximum allowable cost of the interchangeable product, less the PAAD program co-payment. In this case, the PAAD beneficiary can choose to either:

i. Purchase the interchangeable drug product which is equal to or less than the maximum allowable cost, at the PAAD program co-payment; or

ii. Purchase the prescribed drug product which is higher in cost than the maximum allowable cost and pay the difference between the two in addition to the PAAD program co-payment.

5. For MAC drugs (see N.J.A.C. 10:51-4.5), when the prescriber initials "Do Not Substitute," the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill PAAD for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-4.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D Fiscal Agent Billing Supplement for instructions about the claim form.)*

(b) The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-4.20 Drug Efficacy Study Implementation (DESI)

(a) "Less than effective drugs" are subject to a Notice of Opportunity for Hearing (NOOH) by the Food and Drug Administration (FDA).

1. Reimbursement is not available for the purchase or administration of any drug product that meets all of the following conditions:

i. The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962;

ii. The drug product is available only through prescription;

iii. The drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the Federal Register on a proposed

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order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications; and

iv. The drug product is presently *[not subject to a determination by FDA, made under its]* ***the subject of an*** efficacy review study ***performed by FDA*** (see 21 CFR 310.6 including all subsequent amendments and supplements*).* *[, for an explanation of this program), indicating there is a compelling justification of the drug product's medical need.]* ***The FDA efficacy review potentially can determine justification for a drug product's medical need. If a drug product fails this review, the product is classified as a DESI drug.****

2. Reimbursement is not available for the purchase or administration of any drug product that is identical, related or similar, as defined in 21 CFR 310.6 (including all subsequent amendments and supplements), to a drug product that meets the conditions of (a) above.

3. The initial list of drugs and related drug products classified as "less than effective" by the FDA pending outcome of the NOOH appears at 21 CFR 310.6. Subsequent revisions to this list which are adopted, shall appear in the Federal Register.

10:51-4.21 Bundled drug service

(a) "Bundled drug service" means a drug or service that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

(b) Bundled drug service shall not be eligible for reimbursement by the PAAD program. The cost of the drug product which is a component of a bundled drug service (see N.J.A.C. 10:51-4.12, Covered Pharmaceutical Services) shall be covered by the PAAD program.

1. In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the drug product component of the bundled drug service, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625-0712.

10:51-4.22 *[Tape-to-tape incentive program]* ***Electronic Media Claims (EMC) incentive program***

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit PAAD claims *[on magnetic tape]* ***electronically***. Incentive payments shall be made when the total volume of paid *[magnetic tape]* ***electronic media*** Medicaid/PAAD claims, submitted by pharmacy providers as a whole, equals or exceeds 20 percent of the total volume of paid Medicaid/PAAD claims.

(b) The reimbursement for incentive payments is based on the following schedule:

"Percent of total Medicaid/ PAAD Paid Claims"	"Amount of Incentive Payment"
20-29 percent	two cents/tape claim
30-39 percent	three cents/tape claim
40-55 percent	four cents/tape claim
over 55 percent	five cents/tape claim

(c) Claims volume figures shall be reviewed and averaged quarterly. The claim volume totals for the previous quarter shall determine the amount of incentive for the subsequent quarter. If the volume of paid tape claims is less than 20 percent of the total, no incentive payments shall be made. A pharmacy provider shall be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches 20 percent of the total paid claims volume. A qualified *[tape-to-tape pharmacy provider]* ***EMC submitter*** shall receive *[a separate incentive payment check for all tape]* ***payment on their Remittance Advice (RA) Statement for all electronic*** claims paid during the preceding month.

1. Incentive payment for a voided claim(s) shall be deducted from the subsequent month's total incentive payment, which follows the month in which the claim(s) was voided.

(d) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

(e) In order to be eligible to submit magnetic tape claims for the PAAD program, a pharmacy provider shall complete the "New Jersey Medicaid Provider Electronic Billing Agreement," submit the completed agreement to the fiscal agent, and receive approval by the Division of Medical Assistance and Health Services.

10:51-4.23 Eligible PAAD beneficiary

(a) An eligible beneficiary is a permanent resident of the State of New Jersey, 65 years of age or older, or who is under 65 and over 18 years of age and is receiving Social Security Title II disability benefits with an annual income less than *[$15,700]* ***$16,171*** for a single person and less than *[$19,250]* ***$19,828*** in combined income for a married couple, and who possesses a current valid eligibility identification card.

1. Benefits are not payable in nursing facilities, hospitals or special hospitals by the PAAD program during any period recipients are covered for drug benefits by Medicaid, Medicare, Blue Cross and Blue Shield of New Jersey, Inc., or other insurance benefits or if such benefits are covered in the daily rate of the facility.

(b) An applicant shall be determined to be eligible for Pharmaceutical Assistance to the Aged and Disabled only if physically present in New Jersey at the time of application and utilization.

1. Exception: The PAAD program's determination of the continuing New Jersey residence of a person absent from the State of New Jersey shall be based upon whether the individual intends to return to New Jersey or remain indefinitely in the other jurisdiction. If a beneficiary leaves New Jersey with the intent to establish a place of abode elsewhere, he or she becomes ineligible under the PAAD program and shall notify the Bureau of Pharmaceutical Assistance to the Aged and Disabled of the address and return the PAAD eligibility card.

10:51-4.24 PAAD beneficiary identification

(a) Pharmacies should verify that the beneficiary is a PAAD covered person. This is done by checking the beneficiary's plastic PAAD identification card or the Temporary Validation Identification Letter.

(b) The Division shall issue to all PAAD eligibles a Validation Identification Card. The document shall contain the patient's name, PAAD identification number, effective date and expiration date.

(c) The beneficiary is eligible only for the period of time indicated on the identification card.

APPENDIX A

DRUG EFFICACY STUDY IMPLEMENTATION (DESI)

(Update of Drug Products and Known Related Drug Products that Lack Substantial Evidence of Effectiveness)

Appendix A is a list of drugs that the Food and Drug Administration (FDA) has proposed to withdraw from the market which is updated periodically by the Health Care Financing Administration subsequent to published listing changes in the Federal register.

AGENCY NOTE: The Appendix A is filed as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Appendix A, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Appendix A, write to:

Paramax/Unisys
CN-4801
Trenton, New Jersey 08650

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625

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APPENDIX B

UPPER PAYMENT LIMITS FOR MAXIMUM ALLOWABLE COST (MAC) DRUGS

Appendix B is a list of multiple source drugs which meets the criteria set forth in 42CFR 447.301, 331-333 which is updated periodically by the Health Care Financing Administration subsequent to published listing changes in the Federal register.

AGENCY NOTE: The Appendix B is filed as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Appendix B, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Appendix B, write to:

Paramax/Unisys
CN-4801
Trenton, New Jersey 08650

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625

APPENDIX C

PHARMACY PROVIDER CERTIFICATION STATEMENT

Pharmacy Name_____ Provider ID #_____

Address_____

_____ Telephone ( )_____

Section I. ANNUAL CERTIFICATION OF TOTAL PRESCRIPTION VOLUME FOR 1991

Prescriptions Filled: New_____ + Refills_____ = TOTAL *

*Total: Include all third party and non-third party Rxs.
Combine totals for both regular and LTCF numbers, if applicable.

Section II. FEE INCREMENTS ADDED TO BASIC DISPENSING FEE

1. 24-Hour Emergency Service Availability $0.11

Provider certifies availability of 24 hours/day 365 days/year prescription service.

____ Yes ____ No

If yes, service availability made known by:

____ Sign in store window ____ Sign at prescription counter

____ Other Note: If other is checked a complete description of how available must be given.

Telephone number for this service is ( ) _____

Telephone number for this service must be a local call. If telephone number is not given, FD-70 will be returned.

2. Patient Consultation $0.08

Provider agrees to monitor all Medicaid and PAAD patient profiles for drug interactions, contraindications and adverse reactions. Provider will attempt to discuss therapy with the patient with emphasis on compliance and proper utilization of prescription. The pharmacist shall exercise good professional judgment at all times.

____ Yes ____ No

NOTE: If provider discontinues any of the above services, he/she must notify Unisys CN 4804, Trenton, N.J. 08650 in writing within 72 hours of such discontinuance and must immediately cease adding the increments to the basic dispensing fee.

Each of the above claimed increments is subject to audit. If the New Jersey Medicaid Program determines that the provider has an error rate of 5% or more for either increment, the New Jersey Medicaid Program will recover the total reimbursement paid for that increment, plus interest, retroactive to the date of this agreement.

3. Impact Allowance $0.15

This provider has a combined Medicaid/PAAD prescription volume (including LTCF Rxs) equal to or greater than 50% of the total Rx volume & qualifies for "Impact Allowance".

____ Yes ____ No

NOTE: If conditions for earning impact allowance change, provider must notify Unisys, CN 4804, Trenton, N.J. 08650 in writing within 30 days of change and must immediately cease adding the increment to the basic dispensing fee.

If the New Jersey Medicaid Program determines that the provider has not met the impact allowance requirements, the New Jersey Medicaid Program will recover the total reimbursement paid for this increment, plus interest, retroactive to the date of this agreement.

Section III. OWNERSHIP DISCLOSURE STATEMENT

1. Chain Store (4 or more stores). ____ Yes ____ No
2. Do you or does your organization have any legal or professional relationships with any other health care organizations or facilities? ____ Yes ____ No

   If yes, list all such relationships on a separate page.
3. Does any person in your organization own or have an interest in or any relationship with any other corporation, partnership or other organization providing services under the New Jersey Medicaid Program? ____ Yes ____ No

   If yes, explain on a separate page.
4. Indicate the Legal Status of your organization:

   ____ Sole Proprietor ____ Partnership ____ Non-Profit Corporation

   ____ For Profit Corporation ____ Government ____ Other (If so, specify)
5. List names, home addresses, professional degree and percentage of ownership of individual(s) for:

   All partners, directors, officers and/or stockholders as applicable.

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	NAME	DEGREE	HOME ADDRESS	% OWNERSHIP
1.				
2.				
3.				
4.				
5.				

I HAVE THOROUGHLY READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN; I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A MEDICAID OR PAAD PRESCRIPTION FOR A COVERED LEGEND DRUG, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

A. Cost plus dispensing fee is outlined in the New Jersey Medicaid Pharmacy Manual.
B. Usual and customary and/or posted or advertised charge.
C. Average of other third party prescription plan charges or agreements.

THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A COVERED NON-LEGEND PRODUCT, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

A. The manufacturer's published suggested selling price to the consumer.
B. The usual and customary retail price charged to other persons in the community.

Legal Signature of Principal:_____ Date:_____

Print Name:_____ Title:_____

Pharmacy Name:_____

NOTE: All of the above statements are subject to audit and review by Division personnel, its contractors, or other state & federal agencies.

AFFIX
PHARMACY LABEL
HERE

FD-70 (REV. 12/91)

APPENDIX D
FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the fiscal agent billing supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

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CN-4801
Trenton, New Jersey 08650

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Independent Clinic Services
Ambulatory Care/Family Planning/Surgical Facilites
Adopted Amendments: N.J.A.C. 10:66-1.2, 1.6, and 1.7

Proposed: June 21, 1993 at 25 N.J.R. 2683(a).
Adopted: August 16, 1993 by William Waldman, Commissioner, Department of Human Services.
Filed: August 16, 1993 as R.1993 d.444, **without change**.
Authority: N.J.S.A. 30:4D-6a(5), 6b(3); 30:4D-7, 7a, b, and c; 30:4D-12; 42 CFR 440.90; 42 CFR 440.250(c).

Effective Date: September 7, 1993.
Expiration Date: December 15, 1993.

Summary of Public Comments and Agency Responses:

1. COMMENT: Ms. Anita Leone, Executive Director, Family Planning Association of New Jersey, commended the agency for recognizing the higher standards required for ambulatory surgical facilities licensed by the New Jersey State Department of Health and for establishing a new type of clinic provider, ambulatory care/family planning/surgical facility. The commenter pointed out that access to family planning surgical procedures by Medicaid recipients may improve as a result of the proposal's adoption.

RESPONSE: The agency is proceeding to adopt the rules.

2. COMMENT: Ms. Anna Niedelman, Administrator, Alternatives, indicated that the proposed amendment would benefit the women of New Jersey who are Medicaid enrolled because their access to medical care will be improved. Taxpayers in New Jersey will also benefit by the reduced cost of operating the Medicaid program. The commenter enclosed a copy of a hospital bill and provided statistics to show that payments for abortion services in ambulatory surgical facilities are "... a fraction of the hospital costs."

The commenter strongly supports the proposed amendments and, if approved, is willing to become a Medicaid-enrolled provider.

RESPONSE: The agency is proceeding to adopt the rules.

3. COMMENT: Jeff Brand, Executive Director, Planned Parenthood of Greater Northern New Jersey, Inc., strongly supports the proposed regulations, including (a) the recognition of a new clinic category; (b) reimbursement for approved surgical procedures; (c) a facility reimbursement rate equal to 70 percent of the "applicable ambulatory surgical center rate" for the procedures; and (d) physician reimbursement according to specialist and nonspecialist fee allowances.

RESPONSE: The agency is proceeding to adopt the rules.

4. COMMENT: Ms. Phyllis Kinsler, Executive Director, Planned Parenthood of Monmouth County, Inc., supports the proposal to appropriately recognize ambulatory care/family planning/surgical facilities. The commenter indicated that the proposal may assist Medicaid

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recipients in obtaining cost-effective, community-based health care in facilities that meet the comprehensive licensure standards of the New Jersey State Department of Health.

RESPONSE: The agency is proceeding to adopt the rules.

General Agency Response:

The agency's response is to adopt the proposal. It is emphasized, however, that only facilities licensed and authorized by the New Jersey State Department of Health as ambulatory care/family planning/surgical facilities will be reimbursed by the New Jersey Medicaid program for the provision of approved surgical procedures.

Full text of the adoption follows:

10:66-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context indicates otherwise.

. . .

"Ambulatory care/family planning/surgical facility" means a health care facility or a distinct part of a health care facility, licensed as such by the New Jersey State Department of Health to provide specified surgical procedures.

. . .

10:66-1.6 Scope of service

(a)-(i) (No change.)

(j) Surgical services rules for minor surgery in an ambulatory care facility, surgery in an ambulatory surgical center, and other approved surgical services in an ambulatory care/family planning/surgical facility follow:

1.-7. (No change.)

8. Other approved surgical services may be reimbursed when performed in an appropriately licensed ambulatory care/family planning/surgical facility.

(k)-(o) (No change.)

(p) Other services rules are as follows.

1. Abortions may be reimbursed when performed in an appropriately licensed ambulatory care facility, an ambulatory surgical center, or an ambulatory care/family planning/surgical facility licensed and authorized by the New Jersey State Department of Health to perform abortions with specific approval of the New Jersey Medicaid program, subject to the following conditions:

i.-iii. (No change.)

2.-5. (No change.)

10:66-1.7 Basis for reimbursement

(a)-(c) (No change.)

(d) Reimbursement for the services of an ambulatory care/family planning/surgical facility shall be made as follows:

1. Reimbursement shall be made for services rendered by both the facility and the physician.

2. The facility reimbursement rate shall equal 70 percent of the applicable ambulatory surgical center rate for the procedures, in accordance with reimbursement rates, N.J.A.C. 10:66-1.7(c)2iii.

3. Physician reimbursement shall be in accordance with the New Jersey Medicaid program's Physician Maximum Fee Allowance for specialist and non-specialist, N.J.A.C. 10:54, and the following:

i. When submitting a claim, the physician performing the surgical procedure shall use the applicable claim form, billing the New Jersey Medicaid program either as an individual provider or as a member of a physician's group.

ii. A physician on salary for administrative duties (such as a medical director) shall be permitted to submit claims for surgical/medical services performed if outside his or her administrative duties. Administrative duties shall be considered a direct cost of the facility and shall be included in the clinic payment.

CORRECTIONS

(a)

ADMINISTRATION, ORGANIZATION AND MANAGEMENT

Notice of Administrative Changes

N.J.A.C. 10A:1-1.2(c) and 2.7

Take notice that in order to comply with the State Constitution's balanced budget requirement, the position of Regulatory Officer, Division of Policy and Planning, was targeted for elimination within the New Jersey Department of Corrections. Thus, the reference to the Regulatory Officer, Division of Policy and Planning in N.J.A.C. 10A:1-1.2(c) has been deleted. Also, the task of reviewing Form 911-II REQUEST FOR RULE EXEMPTIONS at N.J.A.C. 10A:1-2.7(e) has been reassigned to the appropriate Assistant Commissioner. N.J.A.C. 10A:1-2.7(f) has been deleted and the current subsections (g)-(i) are recodified as subsections (f)-(h).

By this notice of administrative change, published pursuant to N.J.A.C. 1:30-2.7, the necessary changes are being incorporated into the text of N.J.A.C. 10A:1-1.2(c) and 2.7.

Full text of the changed rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]).

10A:1-1.2 Procedure to petition for a rule

(a)-(b) (No change.)

(c) The petition shall be sent to the Commissioner, Department of Corrections, [and to the Regulatory Officer, Division of Policy and Planning,] at CN 863, Trenton, New Jersey 08625.

(d)-(e) (No change.)

10A:1-2.7 Procedure for requesting rule exemptions

(a)-(d) (No change.)

(e) If the Superintendent or the administrative head of a noninstitutional operational unit approves a request for a rule exemption, he or she shall complete, in duplicate, Sections 1 through 6 of Form 911-II REQUEST FOR RULE EXEMPTION, sign and date Section 7 and submit Form 911-II to the [Chief Hearing Officer, Office of the Deputy Commissioner] **appropriate Assistant Commissioner.**

[(f) The Chief Hearing Officer shall review Form 911-II REQUEST FOR RULE EXEMPTIONS and submit Form 911-II to the appropriate Assistant Commissioner along with recommendations for approval or disapproval, based on the criteria at N.J.A.C. 10A:1-2.4(c).]

Recodify existing (g)-(i) as **(f)-(h)** (No change in text.)

(b)

THE COMMISSIONER

Transportation of Inmates Recall to Court

Adopted Amendment: N.J.A.C. 10A:3-9.6

Proposed: July 6, 1993 at 25 N.J.R. 2820(a).

Adopted: August 9, 1993 by William H. Fauver, Commissioner, Department of Corrections.

Filed: August 11, 1993 as R.1993 d.435, **without change.**

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Effective Date: September 7, 1993.

Expiration Date: September 16, 1996.

Summary of Public Comments and Agency Responses:

The Department of Corrections received one comment from Mary C. Williams, Edna Mahan Correctional Facility for Women.

COMMENT: The commenter stated that failing to produce a prisoner in court because a writ did not reach the correctional facility 48 hours

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in advance would cause untold delays in the judicial system and would deny a prisoner meaningful access to the courts and, as such, would violate his or her constitutional right(s).

RESPONSE: The Department of Corrections disagrees that the increase in time from 24 to 48 hours would deny an inmate meaningful access to the courts, violate the inmate's constitutional rights and result in untold delays. Currently, the Administrative Office of the Courts has arranged for correctional facilities to receive writs within a minimum of 48 hours and the Department of Corrections endeavors to make a good faith effort to comply with the writ to produce an inmate. If a writ to produce an inmate is received at the correctional facility less than 48 hours in advance and cannot be processed, the Administrative Office of the Courts will reschedule with the Department of Corrections. Rescheduling usually occurs within a maximum of two weeks.

Full text of the adoption follows:

10A:3-9.6 Recall to court

(a) An inmate shall only be produced in court by a writ of habeas corpus, writ of habeas corpus ad testificandum, post conviction relief order, or other order to produce which is to be at the correctional facility 48 hours prior to the scheduled court appearance.

1.-4. (No change.)

(b) (No change.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CRIMINAL JUSTICE POLICE TRAINING COMMISSION

Notice of Administrative Correction Police Training Commission Rules Operating Entity Responsibilities N.J.A.C. 13:1-7.2

Take notice that the Department of Law and Public Safety, Division of Criminal Justice, has discovered a typographic error in the recent proposed and adopted amendment to N.J.A.C. 13:1-7.2(a)7, published at 25 N.J.R. 1336(a) and 2897(a), respectively. The word "trainer" is a misprint of "trainee," which latter word correctly appeared in the rule at the time of proposal and for which no proposed change was indicated. This notice of correction is published pursuant to N.J.A.C. 1:30-2.7

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

13:1-7.2 Operating entity responsibilities

(a) The law enforcement agency, combination of law enforcement agencies, institution of higher learning, or recognized governmental entity certified to operate a school is vested with the power, responsibility and duty:

1.-6. (No change.)

7. To report immediately the illness or injury of a [trainer] **trainee** or an instructor to an appropriate official in the trainee's or instructor's law enforcement agency and to the Commission staff;

8.-22. (No change.)

(b)

DIVISION OF MOTOR VEHICLES

Transportation of Bulk Commodities Readoption: N.J.A.C. 13:26

Proposed: April 5, 1993 at 25 N.J.R. 1343(a).

Adopted: July 15, 1993 by Stratton C. Lee, Jr., Director, Division of Motor Vehicles.

Filed: July 29, 1993 as R.1993 d.418, **without change**.

Authority: N.J.S.A. 39:5E-5.

Effective Date: July 29, 1993.

Expiration Date: July 29, 1998.

Summary of Public Comment and Agency Response:

No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 13:26.

PUBLIC UTILITIES

(c)

BOARD OF REGULATORY COMMISSIONERS

Administrative Orders Natural Gas Adopted New Rules: N.J.A.C. 14:11-8

Proposed: March 1, 1993 at 25 N.J.R. 897(a).

Adopted: June 23, 1993 by the Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman, and Jeremiah F. O'Connor and Carmen J. Armenti, Commissioners.

Filed: June 24, 1993 as R.1993 d.361, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 48:2-13, 48:3-9, 48:10-2 et seq.

BRC Docket Number: AX92020133

Effective Date: September 7, 1993.

Expiration Date: March 1, 1998.

Summary of Public Comments and Agency Responses:

Comments pertaining to the reproposal of N.J.A.C. 14:11-8 were submitted by:

Richard Fryling, Jr., Esq., General Solicitor, on behalf of Public Service Electric and Gas Company (PSE&G).

Edward J. Sawicki, Jr., Manager—Environmental and Distribution Engineering, on behalf of New Jersey Natural Gas Company (NJNG).

David A. Kindlick, Vice President—Revenue Requirements, on behalf of South Jersey Gas Company (SJG).

Stuart N. Steggall, Vice President—Operations and Engineering, on behalf of Elizabethtown Gas Company (E'town).

Geoffrey A. Emerson, Director—State Regulatory Affairs, on behalf of Panhandle Eastern Corporation (PEC).

(1) COMMENT: PEC seeks clarification that the proposed rules do not include within their scope any interstate natural gas pipeline facilities because such facilities are currently regulated under the Natural Gas Act, 15 U.S.C. 717, and the Natural Gas Pipeline Safety Act, 49 U.S.C. 1671 et seq.

PEC has suggesed the following modification of the language set out in N.J.A.C. 14:11-8.1 in order to alleviate any misunderstanding as to the effect of the proposed rules:

Unless otherwise ordered or permitted by the Board, the rules in this subchapter shall be observed and followed in connection with the construction, operation and maintenance of transmission and distribution pipelines for the transportation of natural gas **by intrastate natural gas pipeline facilities** within [and through] the State of New Jersey.

It is the opinion of PEC that the suggested clarifying language would acknowledge that the Board does not intend to prescribe authorization, construction, operation and maintenance requirements for interstate facilities and that such facilities are already regulated by the Federal Energy Regulatory Commission and the United States Department of Transportation pursuant to 49 C.F.R. Parts 190-199.

RESPONSE: The Board concurs. As it was never its intention that the proposed rules would apply to interstate facilities, the Board will adopt the recommendation of PEC for clarification purposes.

(2) COMMENT: SJG argues that N.J.A.C. 14:11-8.4, which requires Board approval prior to the installation of a pipeline with an operating maximum pressure in excess of 250 psig and which is to be located within 100 feet of a building intended for human occupancy, should be deleted. SJG bases its argument on the fact that Federal regulations do not require such language and that there should be no concern as to the credibility of the line if required design criteria are followed.

RESPONSE: The Board disagrees. While SJG is correct that Federal regulations do not require the language set out in this proposed section,

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the Board, in its discretion, may impose requirements that are more stringent. The Board believes that public policy requires that persons affected by the construction and installation of high pressure gas pipelines should have a forum in which to voice their opinions and concerns regarding those pipelines. In addition, the Board is of the opinion that its Staff should be made aware of such facilities prior to their construction and installation.

(3) COMMENT: PSE&G and SJG argue that the requirement of N.J.A.C. 14:11-8.6 that 20 percent of the welds be radiographically examined in any pipeline construction project involving five miles or more of 16 inch O.D. or larger pipe is acceptable for transmission lines but excessive for distribution lines. They further comment that it is questionable if there is anything to be gained by a 20 percent inspection of welds when all welders are to be pre-qualified. PSE&G and SJG also state that the reference to "paragraph 2" is unclear.

RESPONSE: The Board agrees that the language in this section is somewhat unclear. It should be noted that the provisions contained in the Federal Code pertain to all sizes of transmission and distribution pipelines. Accordingly the last sentence of proposed rule N.J.A.C. 14:11-8.6 is redundant in that the requirements contained therein are already covered in the Federal Code which is referenced in the preceding portion of the rule. Accordingly, the Board will clarify proposed rule N.J.A.C. 14:11-8.6 by deleting the last sentence of the text. The commenters concerns regarding testing being excessive cannot be addressed by the Board since the requirements are those imposed by Federal regulation.

(4) COMMENT: PSE&G, SJG and NJNG are of the opinion that it is neither practical nor necessary for N.J.A.C. 14:11-8.7(c) to impose transmission design criteria (reinforced type branch connections) on distribution systems. They further suggest that subsection (c) is not needed as N.J.A.C. 14:11-8.7(a) requires fabrication details to be in accordance with the Federal Code.

RESPONSE: It has long been the interpretation under the Federal Code, and the practice thereunder, that reinforced branch connections are applicable to only transmission pipelines. As indicated in N.J.A.C. 14:11-8.1, these proposed rules are to apply to "... the construction, operation and maintenance of transmission and distribution pipelines for the transportation of natural gas ..." The core of these proposed rules is the Board's adoption by reference of the Federal Code, which applies to transmission and distribution pipelines. In those cases where the Federal Code has been interpreted as applying solely to either transmission pipelines or distribution pipelines, the Board's proposed rules, for clarification purposes only, should indicate if only one type of pipeline is affected by any particular section of the proposed rules.

(5) COMMENT: PSE&G, SJG and NJNG suggest that N.J.A.C. 14:11-8.9(c), which addresses the use of casings during construction, can be deleted since N.J.A.C. 14:11-8.8 addresses crossings and the requirement to install facilities in accordance with the specification and standards established by the authority or agency having jurisdiction over the right-of-way.

RESPONSE: The Board is of the opinion that no changes are necessary in that N.J.A.C. 14:11-8.8 deals with the installation of pipelines which intersect a railroad or a State highway while N.J.A.C. 14:11-8.9(c) applies to pipelines which are installed beneath or parallel to public hard surface roads or streets.

(6) COMMENT: PSE&G, SJG and NJNG note that N.J.A.C. 14:11-8.10(d) retains the original wording that names, addresses and telephone numbers of representatives are to be furnished to municipalities for emergency services. The utilities feel that because they have a 24 hour emergency telephone number and their personnel may change from day to day, the municipalities would be better served by being advised only of the 24 hour emergency telephone number. In addition, because its duty supervisors rotate work schedules, NJNG argues that submission of the information to the Board would not be practical.

RESPONSE: Pursuant to Part 192.615(a)(8) of the Federal Code, each affected gas operator has the obligation of:

"Notifying appropriate fire, police, and other public officials of gas pipeline emergencies and coordinating with them both planned responses and actual responses during an emergency."

Based upon the foregoing, the Board is of the opinion that the provision of a 24 hour emergency telephone number to the municipalities, in addition to the Federal Code requirements, is sufficient. The Board will modify N.J.A.C. 14:11-8.10(d) accordingly. The Board is of the opinion, however, that while emergency supervisory personnel may rotate working hours or be away from their jobs for reasons such as vacation or illness, the utility should continue to provide this Board with the information required by the proposed rule. The Board has, in the past, found such information to be of assistance in reacting to emergency situations.

(7) COMMENT: PSE&G, E'town and SJG oppose N.J.A.C. 14:10-8.16(e) which would require that all unprotected bare steel service lines be subjected to flame ionization surveys at intervals not exceeding 24 months and the replacement of all bare steel service lines within a definable area when records indicate that 20 percent or more of the services within that area have exhibited leaks. PSE&G argues that, based on experience and economics, there is no need for this requirement. The utility states that its records indicate that not one incident resulting from a corroded unprotected bare steel service has occurred in the period covering 1972 through 1992. SJG makes the same representation covering the period from 1977 through 1992. PSE&G, E'town and SJG further argue that as flame ionization surveys are extremely labor extensive, and that they are replacing unprotected bare steel services in a reasonable and timely manner, the additional annual expense of performing these surveys is not warranted. NJNG questions the meaning of the term "definable area" as set out in the section, and whether there is a timeframe in which the replacement of unprotected steel services must be replaced.

E'town further believes that current Federal regulations address this issue adequately as they require leak surveying of services every five years and any services with active corrosion are to be monitored every three years.

RESPONSE: While unprotected steel service lines exhibit a higher probability of leakage because of corrosion, the Board is of the opinion that the performance of flame ionization surveys at intervals not exceeding five years will be adequate in allowing pipeline operators to detect leaks in their systems and to take remedial action as necessary. The Board would note that the Federal Code requires a pipeline operator to perform leakage surveys at intervals not exceeding five years. These requirements, however, do not specify which types of surveys must be adopted. Therefore, less reliable methods, such as vegetation surveys, which can only detect large scale gas leakages, may be utilized. On the other hand, flame ionization surveys, which are not required by any existing governmental or industry policies, are the most capably known method by which gas can be readily detected in parts per million.

As a result of the comments received, the Board's Staff conducted a review of the operating and incident records of each affected gas utility in order to more definitively determine over what period of time flame ionization leakage surveys could be conducted without compromising the ability of the utility to provide safe, adequate and proper service. Because of the greater sensitivity and detectability afforded by the use of flame ionization surveys, the Board has concluded that a period of five years, rather than two years, is more appropriate and cost effective with regard to the discovery and repair of gas leakages. The Board does not consider this change to be substantive in that the method of leak detection required is much more sophisticated and accurate than any other known method, and that a five year period, which is consistent with the period of time set forth in the Federal regulations set out in 49 C.F.R. Part 192 which pertain to the survey of pipeline systems located outside of a principal business district, will have no negative impact on the ability of the affected gas utilities to detect and repair any leaks in their systems.

(8) COMMENT: PSE&G, E'town, SJG and NJNG suggest that N.J.A.C. 14:11-8.17 be clarified to indicate that it is only meant to pertain to transmission pipelines. To do otherwise would, in the opinion of the utilities, require a two day notice of all small size main extension and basic service installations pursuant to subsection (b) and an excessive testing period of 12 to 24 hours.

RESPONSE: It was always the intent of the Board that N.J.A.C. 14:11-8.17(a) was to pertain to both transmission and distribution pipelines, while (b), (c) and (d) thereof was to be restricted to transmission pipelines. The Board will clarify its intent through the use of the descriptive words "transmission" and "distribution" where appropriate. See also the rationale for change expressed in the response to Comment 4.

(9) COMMENT: PSE&G, SJG and NJNG suggest that the purging of a pipeline with inert gas prior to the activation of the line, as set out in N.J.A.C. 14:11-8.18, is basically a transmission line application and should be so noted.

RESPONSE: While agreeing that the purging of a pipeline with inert gas prior to its activation is primarily an application for transmission

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pipelines, the Board, as has the Federal government, recognized the potential for the formation of a hazardous mixture of gas and air. Accordingly, the Board has provided for the use of inert gas or any other suitable method to prevent the formation of a hazardous mixture in transmission and distribution pipelines.

(10) COMMENT: NJNG takes the position that it is more reasonable that N.J.A.C. 14:11-8.30(b)4 be modified to require $10,000 in property damage to others, rather than the proposed amount of $1,000, before an accident report would be required.

RESPONSE: The Board is of the opinion that $1,000 is a reasonable sum upon which to require the filing of an accident report and would note that this amount is consistent with the provisions of N.J.A.C. 14:11-5.4(b).

(11) COMMENT: NJNG recommends that the proposed requirement to provide the Board with 30 days notice set out in N.J.A.C. 14:11-8.32(a) be restricted to major construction or reconstruction as described in N.J.A.C. 14:11-8.6 (more than five miles of 16 inch pipe) **and** which will operate at greater than 250 psig as noted in N.J.A.C. 14:11-8.4.

RESPONSE: The Board is of the opinion that the 30 day notice for pipelines in excess of 125 psig is consistent with past Board policy. The Board further notes that such notice assists its staff in the scheduling of necessary inspections.

(12) COMMENT: SJG notes that the gas utilities are visited on a weekly basis by Board staff in order that staff may be kept abreast of a variety of company practices and policies including the construction or installation of pipelines and mains. SJG further states that the pressure testing of transmission lines are also witnessed by staff. Based on the foregoing, SJG suggest that N.J.A.C. 14:11-8.32(b) can be deleted without any loss of control. That subsection requires monthly reports to the Board setting forth the progress of the construction or major reconstruction of gas pipelines intended to be operated in excess of 125 psig.

RESPONSE: The Board agrees. Because of the notification provided for in the proposed rule and the subsequent monitoring and inspection of the pipeline by the Board's Staff in the normal course of its duties, the Board is of the opinion that a monthly report will not be necessary. Accordingly, the Board will delete N.J.A.C. 14:11-8.32(b) and redesignate the remaining provisions as N.J.A.C. 14:11-8.32.

(13) COMMENT: SJG recommends that N.J.A.C. 14:11-8.33 be modified to indicate that it applies only to transmission pipelines.

RESPONSE: As this was the intent of the Board, N.J.A.C. 14:11-8.33 shall be modified accordingly. See also the rationale for change expressed in the response to Comment #4.

Summary of Agency-Initiated Changes:

Because the Federal Code does not always recognize the most current edition of either the National Electrical Code or the National Electrical Safety Code, the Board is of the opinion that the standard in effect should be that standard currently recognized by the Federal Code. Accordingly, both N.J.A.C. 14:11-8.24 and N.J.A.C. 14:11-8.27 will be so modified.

As the Board is no longer involved with the design and construction of bridges or passages over or under and across a railroad right-of-way and does not anticipate any future involvement in those activities, the Board is of the opinion that N.J.A.C. 14:11-8.34 is unnecessary and, therefore, should be deleted.

As can be seen in proposed N.J.A.C. 14:11-8.16(e), the Board has provided that the period for flame ionization surveys on all unprotected steel pipe will commence one year from the effective date of the proposed rules. This amendment will not have any adverse effects upon the utility, its system or its customers in that, as previously noted, the Federal Code requires surveys to be done at intervals not exceeding five years. The one year period, however, will provide each affected utility with the necessary time to adequately review its records in order that all unprotected steel service lines may be identified. In addition, it will allow each utility to arrange for the purchase or lease of that equipment which is necessary to conduct the surveys, and to negotiate contracts with outside contractors, if necessary.

The Board would further note that it proposes a change in N.J.A.C. 14:11-8.16(e) that would include for flame ionization surveys, in addition to unprotected bare steel service lines, coated steel service lines which are unprotected. The Board does not consider this change to be substantial in that unprotected coated steel service lines similarly exhibit an increased potential for leakage because of corrosion and that the entire gas industry is aware that all unprotected steel service lines, bare or coated, have required special consideration in determining the frequency of leakage surveys. Therefore, because of usual past considerations in developing gas procedures, the addition of unprotected coated steel service lines will have little effect on the ability of the gas utilities to perform the necessary surveys.

Full text of the adopted rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

14:11-8.1 Scope

Unless otherwise ordered or permitted by the Board, the rules in this subchapter shall be observed and followed in connection with the construction, operation and maintenance of transmission and distribution pipelines for the transportation of natural gas ***by intrastate natural gas pipeline facilities*** within *[and through]* the State of New Jersey.

14:11-8.2 Compliance with Federal Code

Any gas pipeline constructed after *[the effective date of the subchapter]* ***September 7, 1993*** shall be constructed, operated and maintained in compliance with the Code of Federal Regulations, Title 49, Part 192, hereinafter referred to as the "Federal Code," incorporated herein by reference, or such other standard as the Board may from time to time prescribe. Any such pipeline which comes within the scope of the provisions of N.J.S.A. 48:10-2 to 10-9 and which was constructed prior to *[the effective date of these rules]* ***September 7, 1993*** shall be deemed to be subject to any provisions of the Federal Code pertaining to operation and maintenance.

14:11-8.3 Classification of system

(a) Natural gas pipelines shall be classified in accordance with the provisions of the Federal Code. However, no portion of a gas pipeline subjected to pressures of 125 pounds per square inch gauge (psig) or more shall be classified as less than Location Class 3 when such portion of the pipeline is constructed within 300 feet of, or if said pipeline is to be operated at a pressure in excess of 500 psig within 500 feet of the following:

1. A place of residence;
2. A building used for public gathering;
3. Any school building, playground, or building devoted to institutional use;
4. Property that is zoned as residential; or
5. A building devoted to a business in which more than three people are employed when such structures are in existence or under construction at the date of execution of the right-of-way agreement or at the date of filing with the clerk of the Superior Court of a complaint in a condemnation action. This additional classification shall not apply to buildings which are under control of the gas pipeline company.

14:11-8.4 Proscribed areas

Gas pipelines which are to be operated at a maximum pressure in excess of 250 psig shall not be installed within 100 feet of any building intended for human occupancy which is in existence prior to or under construction at the date of execution of the right-of-way agreement or at the date of filing with the clerk of the Superior Court of a complaint in a condemnation action, unless such installation is authorized and approved by the Board.

14:11-8.5 Welding

Welds, other than factory welds, on steel pipe of the physical and chemical properties for which the effective American Petroleum Institute Standard 1104 and Federal Code, hereinafter referred to in this subchapter as Welding Standards, are applicable shall be made in accordance with such Welding Standards, incorporated herein by reference.

14:11-8.6 Quality control of field welding

All pipeline and piping welders shall be qualified in accordance with the requirements for the qualification of welders as set forth in Welding Standards. Throughout the construction period, ***any*** representative samples of welds made by *[each]* ***a*** welder or welding crew shall be removed from the line and tested to destruction in accordance with the provisions of the Welding Standards or

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shall be radiographically examined in accordance with the Welding Standards or examined by any other acceptable methods, the conditions for which are set forth in the Federal Code. *[In any pipeline construction project involving five miles or more of 16 inch O.D. or larger pipe, at least 20 percent of the welds in construction classified under paragraph 2 as Location Class 3 or Class 4 piping and at least 10 percent of the welds in construction classified under paragraph 2 as Location Class 1 or Class 2 pipeline, shall be examined radiographically in accordance with the Welding Standards or examined by other methods deemed to be at least equally acceptable.]*

14:11-8.7 Fabrication details

(a) The requirements set forth in (b) through (d) below in addition to the requirements of the Federal Code shall be applicable to the construction of gas pipelines.

(b) Straight pipe may be bent cold in the field by any of the accepted methods of smooth bending provided that the wall thickness and strength of the pipe after bending is not less than that required under the applicable provisions of the Federal Code for straight pipe of the same diameter and grade.

(c) Branch connections ***for transmission pipelines*** fabricated by welding shall be of the reinforced type made in accordance with the rules for reinforced connections as provided in the Federal Code. However, line taps may be made under pressure in the sizes and at the pressure at which the line tapping equipment is recommended for use by the manufacturer, provided that all proper safeguards against injury to persons and property are taken.

(d) Mitre welds shall be made in accordance with the Federal Code.

14:11-8.8 Crossings

At points where a natural gas pipeline intersects a railroad or a New Jersey State Highway, such pipeline shall be installed in accordance with the specifications and standards established by the authority or agency having jurisdiction over the right-of-way.

14:11-8.9 Lines under or adjacent to railroads and highways

(a) Every gas pipeline constructed and operated within the boundaries of a railroad right-of-way or a public hard surface highway or street or within 25 feet thereof, shall conform to the standards and requirements of the Federal Code for gas pipelines in Location Class 3 or 4.

(b) In the construction of any gas pipeline parallel to railroad tracks, consideration shall be given to the character of the railroad traffic and the pressure and diameter of the gas pipeline in establishing the following:

1. The minimum amount of cover required over such pipeline;

2. The minimum proximity of the gas pipeline to the railroad track;

3. The need for additional valves to permit the prompt shutting off of gas in the event of pipeline failure or any other emergency; and

4. The need, if any, for casing.

(c) Whenever reasonably possible to avoid doing so, a gas pipeline subjected to or intended to be subjected to pressure in excess of 125 psig, should not be installed beneath and parallel to or within 25 feet of any public hard surface road or street. When such a gas pipeline is so installed the construction shall conform, as far as casing is concerned, to the provisions of N.J.A.C. 14:11-8.8 to the extent reasonably practicable.

(d) Notwithstanding the provisions of N.J.A.C. 14:11-8.8, all applicable rules of other State or local agencies having jurisdiction which exceed the requirements of said rules shall be effective.

14:11-8.10 Valve spacing

(a) Shut-off valves shall be installed and maintained at strategic points on the pipeline system at intervals which will permit sections of the line to be isolated.

(b) In areas outside the boundaries of cities and villages where there are no houses within 300 feet of the pipeline, the appropriate length of such sections shall not be greater than 16 miles; and where houses are located within 300 feet of the pipeline, the appropriate length of such sections shall not be greater than eight miles.

(c) Within the boundaries of cities and villages or in the vicinity thereof, sufficient additional valves shall be provided and other appropriate steps taken to provide means for promptly turning off the gas and rapidly reducing the pressure in any section of pipe in the event of a pipeline failure or other emergency.

(d) Each pipeline company shall designate a representative or representatives in New Jersey who are familiar with the location and operation of the shut-off valves. The names, addresses and telephone numbers of these representatives shall be furnished to the Secretary of the Board *[and to the clerks of the municipalities through which the line is laid.]* Such representatives shall be available at all times for emergency services. ***The clerks of the municipalities through which the line is laid shall be furnished with a 24 hour emergency telephone number in addition to any obligations that the pipeline company may have to the municipalities pursuant to the Federal Code.***

14:11-8.11 Automatic valves

Automatic valves should only be installed where the particular circumstances indicate that they will contribute to safer operation.

14:11-8.12 Blow-offs

Automatic blow-off or pressure relieving devices shall be installed in such a manner that the released gas will not present a hazard to nearby persons or property. Manually operated blow-off valves shall be operated in such a manner as to avoid hazard to nearby property or persons.

14:11-8.13 Installation of pipe

Inspection for storage and handling of pipe shall be adequate to assure that the pipe installed will be free of nicks or other forms of damage which would tend to produce a concentration of stresses or otherwise reduce the strength of the pipe below the minimum required under the applicable provisions of the Federal Code for the services conditions at which it is intended to operate the pipeline.

14:11-8.14 Minimum cover of mains

(a) Gas pipelines within the scope of this subchapter shall be laid with a cover of not less than 24 inches above the top of the pipe except where interference with other subsurface structures makes it impracticable to maintain this depth of cover, in which event the pipe shall be cased or protected with a suitable shield of metal. Gas pipelines shall be laid so as to avoid other subsurface structures and such pipelines shall not be laid within the distance of less than 12 inches from any other subsurface structure whenever reasonably practicable to avoid doing so. A structure providing a space in which a substantial volume of an explosive mixture might accumulate in the event that gas escapes from the pipeline shall be avoided when reasonably practicable to do so and preference shall be given to crossing over rather than under such structures.

(b) Whenever conditions permit, gas pipelines within cities and villages shall be laid with a cover of not less than 36 inches above the top of the pipe.

14:11-8.15 Projections

Any portion of a pipeline which protrudes above the ground shall be conspicuously painted, marked or fenced or otherwise protected against damage or tampering.

14:11-8.16 Corrosion control

(a) Except as provided in (b) below, each buried or submerged metallic pipeline installed after July 31, 1971, shall require an external protective coating and a cathodic protection system designed to protect the pipeline in is entirety in accordance with the Federal Code, installed and placed in operation within one year after completion of construction. An operator need not comply with this provision if tests, investigations or experience demonstrate that:

1. A corrosive environment does not exist with regard to copper pipelines; or

2. Corrosion during the life of a temporary pipeline (not to exceed five years of service) will not be detrimental to public safety.

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(b) Each buried or submerged metallic pipeline installed prior to August 1, 1971, shall conform to the requirements as set forth in the Federal Code.

(c) Whenever pipe coating is applied, the following additional precautions should be taken by the company:

1. Tests and inspections shall be made before backfill to insure that the coating is adequate and satisfactory;

2. During backfill, precautions shall be taken to insure the coating is not damaged; and

3. On completion of backfill, tests shall be made to ascertain if the coating is adequate and satisfactory.

(d) After installation of a pipeline, periodic inspection or tests of the line shall be conducted to determine whether or not the pipe metal is adequately protected. Each company shall maintain a suitable log, indicating the character and results of periodic inspection tests.

(e) ***Beginning September 7, 1994,*** *[Each]* ***each*** operator shall perform flame ionization surveys on all *[unprotected]* bare ***and coated unprotected*** steel service lines at intervals not exceeding *[24 months]* ***five years***. The survey results shall be summarized and maintained by the utility, along with the original surveys. Replacement of all bare steel service lines within a definable area shall be required when records indicate that 20 percent or more of the services within that definable area have exhibited leaks.

14:11-8.17 Testing

(a) Testing of all natural gas ***transmission and distribution*** pipelines shall be performed in accordance with the provisions of the Federal Code.

(b) The Board shall be notified at least two working days prior to pressure testing of any gas ***transmission*** pipeline. Officials of municipalities wherein a line is to be tested shall also be notified in order that proper and adequate police protection may be provided.

(c) When water is used for ***the*** testing ***of a gas transmission pipeline***, suitable provisions shall be made for disposal of the water on completion of the test. Suitable precautions shall also be taken to avoid contamination of local streams or water supplies in the event of a line failure.

(d) Test pressure, in accordance with *[the aforementioned]* ***(b) and (c) above***, shall be maintained wherever possible for a period of 24 hours but in no event for a period of less than 12 hours.

14:11-8.18 Purging

Air shall be purged from pipelines classed under N.J.A.C. 14:11-8.3 as Location Class 2, 3, or 4 piping systems by introducing a suitable quantity of inert gas into the pipelines ahead of the combustible gas, or by any other suitable method which prevents formation of an explosive mixture in the pipeline.

14:11-8.19 Piping

Gas piping in gas compressor stations shall be installed in accordance with the provisions of the Federal Code applicable to compressor station piping.

14:11-8.20 Relief devices

Pressure relief or other adequate protective devices of sufficient capacity and sensitivity shall be installed and maintained to assure that the maximum allowable working pressure of the station piping is not exceeded. Suitable provisions shall be made for safely disposing of the gas released from such devices. Periodic tests and inspections shall be made to assure continued sensitivity of these devices.

14:11-8.21 Remote safety shut-downs

Each compressor station with installed horsepower of more than 1,000 and operating at pressures in excess of 250 psig shall be provided with remote emergency shut-down devices which will allow the station to be shut down from a remote point, away from the compressor building.

14:11-8.22 Clearance

Compressor stations to be located on gas pipelines shall not be constructed in areas where such construction is prohibited under applicable zoning regulations and laws. At locations where a compressor station is constructed, the distance between a building not under the control of the pipeline company and intended for human occupancy and the main compressor room of the compressor station which is intended to operate at pressures in excess of 250 psig shall not be, at the time of construction of the station, less than the distance indicated in the following table:

Installed Horsepower	Distance from Structure in Feet
Under 1,000	250
1,000 and over	500

14:11-8.23 Fire prevention

Supplies of gasoline, lubricants, paints and other similar combustible materials in excess of those required in actual operation shall be stored at a safe distance from the compressor building. Gas engine crankcases shall be vented outside the building with a vent not smaller than the connection provided by the compressor manufacturer. Warning signs adequate to indicate the danger involved shall be placed in conspicuous locations around the compressor station area.

14:11-8.24 Electric installations

All electric wiring, fixtures and devices within compressor buildings shall be designed and installed in accordance with Article 500 of the *[current]* edition of the National Electrical Code ***currently recognized by the Federal Code,*** and shall meet the requirements thereof for Class I locations and shall also conform to applicable provisions of the *[current]* edition of the National Electrical Safety Code ***currently recognized by the Federal Code***, incorporated herein by reference.

14:11-8.25 Ventilation

Compressor stations shall be provided with adequate natural draft ventilating devices.

14:11-8.26 Piping

All gas piping in meter and regulator stations shall comply with the requirements of the Federal Code for such piping

14:11-8.27 Electric installations

All electric wiring fixtures and devices in meter and regulator station buildings shall be designed and installed in accordance with Article 500 of the *[current]* edition of the National Electrical Code ***currently recognized by the Federal Code*** and shall meet the requirements thereof for Class I locations, and shall also conform to applicable provisions of the *[current]* edition of the National Electrical Safety Code ***currently recognized by the Federal Code***.

14:11-8.28 Ventilation and protection, transmission lines

Meter and regulator stations located on gas pipelines shall be provided with adequate ventilation. Any such station constructed underground shall be provided with double duct ventilation, each duct to be of a size sufficient to insure adequate ventilation but not less than four inches in diameter and shall extend a suitable height above ground level. All regulator stations located on gas pipelines shall be provided with a sufficient number of relief valves or other protection devices to insure that the complete failure of one or more regulator stations shall not impose pressures on any part of the transmission system beyond those which it is designed for or protected against.

14:11-8.29 Odorization

(a) All gas transmitted by gas pipelines having an insufficient odor of its own to serve as a warning agent in the event of the escape of unburnt gas shall be odorized with a suitable odorant. The Board shall be notified of the type of odorant used and the rates at which it will be added to the gas and the location of the odorization stations. A suitable log shall be kept showing the quantity of odorant added and the volume of gas odorized. Periodic tests should be made at various points in each transmission system to determine the adequacy of the odorization of the gas and a suitable record of such tests should be maintained.

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(b) Equipment for introduction of the odorant into the gas shall be so designed as to provide a uniform level of odor in the gas. The equipment and facilities for handling the odorant shall be located where the escape of odorant would not be a nuisance.

14:11-8.30 Accidents

(a) Each gas pipeline company shall keep a record of and report to the Board all accidents which come within the meaning of reportable accidents as defined in this subsection, occurring in connection with the operation of the utility's plant property or facilities within the State.

(b) For the guidance of gas pipeline companies, a reportable accident is defined as an accident other than a motor vehicle accident that results in one or more of the following circumstances:

1. Death of a person;
2. Serious disabling or incapacitating injuries to persons, including employees of the company;
3. Damage to the property of the company which materially affects its service to the public; and
4. Damage to the property of others amounting to more than $1,000.

(c) The Board shall be notified promptly by the speediest means of communication available of all accidents which are clearly reportable and those which there is good reason to believe may result in "reportable accidents" as defined herein. If such notification is not given in any case for the reason that the accident is not considered reportable, and it subsequently develops that the accident is reportable, the gas pipeline company involved shall notify the Board immediately after it has been ascertained that such accident is reportable.

14:11-8.31 Interruptions

Service interruptions affecting customers in New Jersey shall be reported to the Board promptly by the speediest means of communication available. However, interruptions to service made in accordance with provisions set forth in contracts between gas pipeline companies and their customers need not be reported.

14:11-8.32 Proposed construction

[(a)] At least 30 days prior to the construction or major reconstruction of any gas pipeline intended to be subjected to pressure in excess of 125 psig, a report shall be filed with the Board setting forth the specifications of such pipeline.

[(b) Every gas pipeline company shall, on the 15th day of each month, submit a report to the Board setting forth the progress of such construction or major reconstruction as of the end of the preceding month.]

14:11-8.33 Compliance; supplementary data on tests

(a) Before a ***transmission*** pipeline is placed in operation, a statement shall be submitted to the Board certifying that the pipeline has been tested and meets the requirements of the Federal Code and other rules herein for the maximum service pressure at which it will be operated. This statement shall also include:

1. Pressures at which the lines were tested;
2. The computation of maximum allowable working pressures in conformity with the provisions of the Federal Code; and
3. The results of leakage or tightness tests made on the line.

(b) No gas pipeline shall be operated at pressures in excess of the pressure for which it was certified to the Board.

(c) In instances where gas pipelines which come within the scope of N.J.S.A. 48:10-2 to 10-9 were placed in service prior to the effective date of these rules, a statement shall be filed with this Board within 60 days of the effective date of said rules indicating:

1. The nature of such test such pipeline was subject to before being placed in service;
2. The pressures at which the lines were tested;
3. Computation of maximum allowable working pressure; and
4. The results of leakage or tightness tests made on such line.

*[14:11-8.34 Design consultants

(a) Whenever the Board participates in the payment of the expense of the construction of a bridge or passage over or under and across a railroad right-of-way where such right-of-way intersects a road, street or avenue, the design work for such construction shall be performed by the Board, the railroad or by a competent consultant engaged by the Board as may be directed by the Board.

(b) Whenever the Board participates in the payment of the expense of the installation of protective devices at railroad grade crossings, the design work may be performed by a competent consultant engaged by the Board.]*

TRANSPORTATION

(a)

DIVISION OF ROADWAY DESIGN
BUREAU OF UTILITY AND RAILROAD ENGINEERING
Utility Accommodation
Readoption with Amendments: N.J.A.C. 16:25

Proposed: June 7, 1993 at 25 N.J.R. 2217(a).

Adopted: July 19, 1993 by William D. Ankner, Director, Division of Policy and Capital Programming, Department of Transportation.

Filed: August 9, 1993 as R.1993 d.433, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:1A-13, 27:7-19, 40:62-35, 65 and 134; 48:7-1; 48:7-2 et seq.; 48:9-17 and 25.4; 48:13-10; 48:17-8 and 16; and 48:19-17.

Effective Date: August 9, 1993, Readoption;
September 7, 1993, Amendments.

Expiration Date: August 9, 1998.

Summary of Public Comments and Agency Responses:

The New Jersey Department of Transportation (Department) is readopting N.J.A.C. 16:25, Utility Accommodation, with amendments. The proposed readoption with amendments was published on June 7, 1993, at 25 N.J.R. 2217(a). A public hearing was held on the proposed readoption with amendments on June 24, 1993, in the Department's Multi-Purpose Room at 1035 Parkway Avenue, Trenton, N.J. from 1:00 P.M. to 3:00 P.M. Mr. John Mycoff, hearing officer, reported that the total number of persons attending the hearing was eight, of which seven represented various utility companies. One person represented the Monmouth County Highway Department. The utility companies represented at the hearing were the Hackensack Water Company, the Eatontown Water Company, PSE&G, and Atlantic Electric. The hearing officer for the Department was Mr. John Mycoff. The hearing was convened and testimony requested on three occasions. None of the attendees wished to provide testimony or make any specific comments regarding the rule proposal. Therefore, Mr. Mycoff had no recommendations to make to the Department.

The hearing record may be reviewed by the public by contacting Mr. Charles L. Meyers, Administrative Practice Officer, Department of Transportation, 1035 Parkway Avenue, Trenton, N.J. 08625, telephone (609) 530-2036.

The Department received five written comments concerning the proposal from:

1. Mr. Richard Fryling, Jr., General Solicitor, Public Service Electric and Gas Company, Newark, New Jersey;
2. Richard M. Stokes, Esq., Manager, Government Affairs, Atlantic Electric, Pleasantville, New Jersey;
3. Mr. John J. O'Brien, Manager, Transmission Lines, Jersey Central Power and Light Company, Morristown, New Jersey;
4. Mr. Daniel A. Oldt, Vice President of Engineering, South Jersey Gas Company, Folsom, New Jersey; and
5. Mr. James P. Scott, P.E. Director of Operations Engineering, American Water Works Service Co., Inc., Eastern Region, Haddon Heights, New Jersey.

General

COMMENT: One comment to the Department reads as follows:

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"We agree with the intent of the proposal to insure a safe and modern highway system. We are also appreciative of the concern of the Department in supplying safe and adequate utility services for our customers. We support this cooperative spirit of the Department and recognize the inherent advantages of working together to insure a consistent and safe infrastructure system in New Jersey."

RESPONSE: The Department concurs with this viewpoint and appreciates the comment.

N.J.A.C. 16:25-1.6

COMMENT: Some private or developer projects near Department right-of-way require utility relocations. The Department should add specific language to its rules requiring that applicants for DOT permits must pay utility companies for the relocation of utility facilities.

RESPONSE: When it is necessary to relocate a utility to accommodate a Department project, the entity responsible to pay the cost for the relocation is set by N.J.S.A. 27:7-44.9. It is not the role of the Department, however, to unilaterally require and to enforce payments to utility companies for utility relocations which do not involve a Department project. While it is true that third party projects sometimes involve utility relocations paid for by the third party, it would be inappropriate for the Department to make itself a collection agency by way of these rules. In respect to third party projects and related utility relocations, the Department will cooperate and fulfill any of its obligations in a timely fashion. The Department does require that documentation be submitted indicating that "reimbursement for utility relocation costs has been addressed in a manner satisfactory to the utility owner."

N.J.A.C. 16:25-1.7(c)

COMMENT: The restrictions set forth should be eliminated. Natural gas utilities are empowered under N.J.S.A. 48:9-17 to lay conductors and install related facilities through the streets and public places, subject only to reasonable regulations not inconsistent with Title 48. If there is a dispute between the governing official having control over a public highway and a utility, the Board of Regulatory Commissioners (BRC) has the jurisdiction to resolve the matter. Similarly, electric utilities are empowered under N.J.S.A. 48:7-2 to lay pipes or conduits and wires beneath public highways in accord with Board of Regulatory Commissioners requirements provided only that such facilities shall not unnecessarily interfere with public travel. The nature of the regulatory prohibition of the installation of utility facilities goes beyond a measurement of reasonableness and, thus, usurps the authority of the BRC.

RESPONSE: The Commissioner of Transportation is vested by law with the responsibility to oversee transportation in the State and to maintain State highways and their rights-of-way. The interstate highway system and many limited access highways were built with Federal Highway Administration funds and are subject to numerous conditions and restrictions regarding access and utility accommodation. Numerous conditions on right-of-way use are enforced both in New Jersey and across the nation. The Board of Public Utility Commissioners, now known as the Board of Regulatory Commissioners, has concurred with the orders of the Commissioner of Transportation which limit the use of some rights-of-way, in conformance with applicable Federal and State requirements regarding access and utility accommodation. The Board of Regulatory Commissioners has not claimed that the subject rules, nor their administration by the Department, usurp its authority. Therefore, given these circumstances, the Department believes it is not usurping the authority of the Board of Regulatory Commissioners, and the requested change has not been made.

N.J.A.C. 16:25-1.7(d)1

COMMENT: The Department should permit overhead utility facility placement when underground placement is cost prohibitive or inefficient.

RESPONSE: On a case-by-case basis, the Department will consider overhead utility installation in lieu of underground placement. This would only be allowed in cases of "extreme need," such as where underground placement would be excessively cost prohibitive or impossible. The Department will only grant such waivers in exceptional circumstances.

N.J.A.C. 16:25-1.7(d)2 and 3

COMMENT: The restrictions set forth are too onerous, in derogation of the jurisdiction vested in the New Jersey Board of Regulatory Commissioners ("BRC"), and should be eliminated.

RESPONSE: The Department does not question that public utilities have various rights in law to occupy various highway rights-of-way. However, in connection with interstate highways and various limited access highway rights-of-way, the Commissioner has exercised his right and certain obligations to relocate utilities from these select rights-of-way and to strictly limit future utility occupancy. The Board of Public Utility Commissioners, now known as the Board of Regulatory Commissioners, concurred in utility orders and agreements that were entered into with utility owners affected by initial construction of the interstate highway system. The actions of the Department in this respect conform with applicable Federal requirements, are not contrary to State law, and do not usurp the authority of the Board of Regulatory Commissioners. Therefore, other requested change has not been made.

N.J.A.C. 16:25-1.7(d)2

COMMENT: The following specific language should be eliminated: "The public utility facility shall not be used for transmitting gases or liquids under pressure, or for the transmission of products which are flammable, corrosive, expansive, energized or unstable."

RESPONSE: No substantive change was made to this specific language between the prior Department rules and the newly readopted rules. The Department believes that gases or liquids under pressure which are flammable, corrosive, expansive, energized or unstable should be strictly controlled. In exceptional cases, the Commissioner can grant waivers to this prohibition. In the interest of protecting the public safety, the Department believes that the restrictions of this section should be continued and not diminished. Therefore, the requested change has not been made.

N.J.A.C. 16:25-3.5(a)

COMMENT: The original wording "casings may be required for the following conditions" is more appropriate. This allows the regional maintenance office to issue a permit for an open-cut trench without requiring a waiver.

RESPONSE: Prior rules of the Department made casings for utility lines generally optional, except when required by the Department. The new rules make casings mandatory, except in those situations where the Department waives the requirement. The Department believes that it is not unreasonable to require casings. Casings provide a measure of protection to a utility line during excavations and are already a standard practice in many circumstances. Utility companies have ready recourse to request a waiver when they can establish that a casing is either not necessary or undesirable. The Department believes that the rule is not unreasonable and would not impose undue hardships; and has, therefore, made no change.

N.J.A.C. 16:25-3.6(a)

COMMENT: "Non-easement" should be "non-encasement."

RESPONSE: The term should read "non-encasement." This is a typographical error in the text and will be corrected in the final rule as a technical change not requiring additional public notice and comment.

N.J.A.C. 16:25-3.13(a)2ii

COMMENT: The text which says "The top of the pipe is within 18 inches or determined to be too close to highway grade," is unclear.

RESPONSE: Upon reading the cited text in its full context within the rules, the language could be improved. The cited text will be clarified in the final rule as a technical change not requiring additional public notice and comment.

N.J.A.C. 16:25-5.1(b)

COMMENT: The Department should permit above ground facilities within grade separated interchange areas where the non-limited access highway use is a local, county, or other State roadway and safety is not compromised.

RESPONSE: This restriction is consistent with preexisting Federal and State requirements regarding utility accommodation on interstate and other limited access highways. The presence of a grade separated interchange for local, county, or other State roadways is not sufficient unilateral grounds for the waiving utility accommodation standards. In cases of extreme need, and where no other options exist, waivers can be requested on a case-by-case basis.

N.J.A.C. 16:25-5.4(a)

COMMENT: This requires utility poles to be constructed "as close to the right-of-way line as practical." It is too restrictive.

RESPONSE: The Department believes that the commenter is misinterpreting the Department's intent regarding this section. It is not the intent of the Department to prohibit pole placement by utilities. The adopted rule gives utility companies considerable latitude in the safe

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placement of utility poles. For those locations where standard specifications cannot be readily met, the Department will work with the utility company to find safe and suitable alternatives.

COMMENT: The Department should eliminate the numerical distances when facilities are to be located close to the right-of-way line. Keeping the present numbers may limit the utilities' ability to utilize cost effective designs or create an undue burden on adjoining property owners in certain areas with minimal building setbacks.

RESPONSE: The standard for location of utility poles is not "numerical," but as close to the right-of-way line as "practical." The Department will work with utility companies to find suitable, safe locations for utility facilities whenever it is possible to do so.

N.J.A.C. 16:25-5.5(c)

COMMENT: The Department is to be complimented in recognizing the need at times to place poles in islands of 100 feet or less. To prohibit the placement of poles in such situations could require large diameter poles along the highway and create other unacceptable conditions. It is requested that the criteria for placing poles in these situations be individually established, based on the merits of the specific project.

RESPONSE: It is the intent of the Department to work with utility companies to accommodate utility facilities in a safe and cost effective manner. Actions of the Department will be consistent with applicable State and Federal laws and guidelines. The Department will consider unique utility accommodation or placement needs on a case-by-case basis.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 16:25.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

16:25-1.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

...

"Cap" means rigid structural element surmounting a pipe or conduit system.

...

"Clear Zone Area" means that roadside border area, starting at the edge of the traveled way, available for safe use by errant vehicles.

...

"Conduit or Duct" means an enclosed tubular runway for protecting wires or cables.

...

"Limited access highway" means a highway, especially designed for through traffic, over which abutting lot owners have no right to light, air, or direct access. Interstate highways, parkways, and freeways are considered limited access highways.

...

"Manager, Bureau of Utility and Railroad Engineering" means the individual authorized by the Commissioner of the Department of Transportation to prepare utility agreements covering rearrangement and/or occupancy of State highways or freeways by utilities in connection with all roadway construction and/or improvement projects.

...

"Permit" means the document by which the Commissioner of the Department of Transportation approves the use and occupancy of highway rights-of-way or property by any utility facility. Permits are not required where Utility Agreements are to be issued in connection with highway improvements.

...

"Public utility" means and includes every individual, copartnership, association, corporation or joint stock company, their lessees, trustees, or receivers appointed by any court, owning, operating, managing or controlling within the State of New Jersey a steam railroad, street railway, traction railway, canal, express, subway, pipe line, gas, electric, light, heat, power, water, oil, sewer, telephone, telegraph system, plant or equipment for public use under privileges granted by the State or by any political subdivision thereof. Although this chapter primarily concerns public utilities, private utilities may also, if installed in accordance with N.J.A.C. 16:25-11.3, occupy highway rights-of-way. The term utility(ies) when used herein is intended to reference both public and private utilities unless they are individually specified.

"Public Utility Agreement (P.U.A.)" means the document by which the Commissioner of Transportation, in connection with limited access highways enters into an agreement with a public utility, a utility not covered by N.J.S.A. Title 48, or a utility having compensable property rights as to the removal and/or relocation of its facilities. Also the document by which the Commissioner of the Department of Transportation, in connection with State highways (non-freeways or parkways) enters into an agreement with the owner of any utility type facility occupying State highway rights-of-way as to the removal and/or relocation thereof. The Agreement further serves as the permit to occupy highway rights-of-way and specifies the requirements for, and the conditions of said occupancy.

"Railroad at grade crossings" means crossings where the railroad track and the highway pavement intersect at the same vertical grade and provide for the operation of rail traffic crossing the highway as well as highway and pedestrian traffic crossing over the railroad track.

"Railroad grade separated crossings" means crossings where either the railroad or the highway is carried over or under the other.

"Regional Maintenance Office" means an office under the jurisdiction of the Executive Director of Regional Operations, Department of Transportation.

...

"Rigid Pipe" means pipe designed for diametric deflection of less than one percent.

...

"Semi-rigid Pipe" means pipe designed to tolerate diametric deflection from 1.0 percent to 3.0 percent.

...

16:25-1.2 Rights-of-way

(a) In the State of New Jersey public utilities have the right by franchise, to occupy highway rights-of-way. The Commissioner of Transportation has the right, by law, to regulate and control the manner in which such occupancy shall be accomplished.

(b) The rules contained in this chapter formally establish the criteria used by the Commissioner of Transportation in controlling the use of rights-of-way of State highways, parkways and freeways.

16:25-1.3 Applicability

The rules contained in this chapter apply to all utilities, including electric ower, telephone, telegraph, cable television, water, gas, oil, petroleum products, steam, chemicals, sewage, and similar facilities that are to be located, adjusted, or relocated within the rights-of-way under the auspices of the New Jersey Department of Transportation. Such utilities may involve underground, surface, or overhead facilities, either singularly or in combination.

16:25-1.5 Standards and references

(a)-(b) (No change.)

[1]Standard Specifications for Road and Bridge Construction. New Jersey Department of Transportation, 1983 as amended or superseded.

[2](No change.)

16:25-1.6 Authority of utilities to use and occupy the rights-of-way of State highways (land service roads)

(a) The rights public utilities have in State highways are established by N.J.S.A. 48 and N.J.S.A. 40.

1. Where usage is permitted, the statutes typically provide that the public utility involved "may use the public highways, streets and alleys", subject to the consents for approvals as the statute may require. Included in this category are:

i.-vi. (No change.)

vii. Electric poles—N.J.S.A. 40:62-35;

viii. Water lines—N.J.S.A. 40:62-134 and 40:178-40.

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16:25-1.7 Limited access highways

(a)-(b) (No change.)

(c) The Department will take under consideration claims of extreme cases of need when a public utility can demonstrate that alternate locations are not available or cannot be implemented at reasonable cost, as determined by the Department, in consultation with the Federal Highway Administration (FHWA), from the standpoint of providing efficient public utility services in a manner conducive to safety, durability, and economy of maintenance and operations; that the accommodation will not adversely affect the design, construction, operation, maintenance, or stability of the limited access highways; that it will not interfere with or impair the present use or future expansion of the limited access highways; and that disapproval of the use of the right-of-way would result in the loss of productive agricultural land, or loss of productivity of agricultural land, if any.

(d) The Department's safety criteria are as follows:

1. The public utility facility shall be placed underground;

2. The public utility facility shall not be used for transmitting gases or liquids under pressure, or for the transmission of products which are flammable, corrosive, expansive, energized or unstable;

3. The public utility facility shall not emit any measurable radiation above the ground surface;

4. The public utility facility shall present no hazard to life, health or property, if it fails to function properly, is severed, or otherwise damaged; and

5. After the public utility facility is installed, it will be virtually maintenance free.

(e) (No change.)

(f) If the Department finds that public utility projects for the installation of a fiber-optic cable or system meet the safety criteria established in (d) above, and if extreme cases of need are demonstrated, such projects will qualify for permit approval. The installation of a fiber-optic cable or system shall be in accordance with N.J.A.C. 16:25-7A.

(g)-(h) (No change.)

16:25-2.1 Locations of utility lines

(a) Utility lines installed within a highway right-of-way require a permit issued by the Department. A public utility agreement, as defined in this chapter with the Bureau of Utility and Railroad Engineering shall serve as a permit. Utility lines must be located to permit servicing such lines with minimum interference to highway traffic and to minimize need for later adjustments to accommodate future highway improvements.

(b)-(c) (No change.)

(d) The horizontal and vertical location of utility lines within the highway right-of-way limits must conform with the clear roadside policies applicable for the system, type of highway, and specific conditions for the particular highway section involved. The location of above ground utility facilities must be consistent with the clearances applicable to all roadside obstacles for the type of highway involved. With pole type facilities, where a guide rail is present, poles should always be located behind the guide rail allowing sufficient clear distance behind the guide rail for the guide rail's design deflection in accordance with N.J.A.C. 16:25-5.5.

(e)-(g) (No change.)

16:25-2.2 Design of utility facilities

(a)-(b) (No change.)

(c) Utility installations on, over, or under the rights-of-way of State highways and utility attachments to highway structures must meet the following minimum requirements:

1.-4. (No change.)

5. Fiber-optic communication facilities installation standards shall conform with the currently applicable sections of the Standard Codes of the American National Standard Institute (ANSI)—E1A472-B, 472B-XX0, incorporated herein by reference.[5]

(d)-(f) (No change.)

footnotes 1-4 (No change.)

[5]ANSI Standard Code for Fiber-Optic Facilities E1A472-B, 472B-XX0 of the American National Standards Institute, 1430 Broadway, New York, New York 10018.

16:25-2.3 Waivers

(a) No waivers or other relief from design standards or other provisions of N.J.A.C. 16:25-3.5 may be granted unless the waiver can be granted without substantial detriment to the safety and operation of the highway and without substantially impairing the intent and purpose of this chapter.

(b) If an applicant wishes to seek a waiver, a request must be submitted to the Department as an attachment to the permit application. The request for waiver shall state reasons why a waiver is appropriate and include documentation to support the waiver.

(c) If a waiver is granted, the approval will be incorporated in the conditions of the permit or agreement.

16:25-3.4 (Reserved)

16:25-3.5 Encasement

(a) Casing shall be required for the following conditions:

1.-3. (No change.)

(b)-(g) (No change.)

16:25-3.6 Allied mechanical protection

(a) When a waiver is granted for *[non-easement]* ***non-encasement***, installation shall be limited to open trenched construction. The following controls shall be applied for providing allied mechanical protection to an uncased pipeline crossing a highway.

1.-3. (No change.)

16:25-3.7 Appurtenances

(a) Vents, drains, markers, manholes, and shut-offs are appurtenances to pipeline installations. Required controls for such appurtenances are as follows:

1.-3. (No change.)

4. New manholes shall normally not be located in the pavement of major highways, including urban highways. Exception may be made at those locations where manholes are essential parts of existing lines that are permitted to remain in place under existing and proposed roadways provided the installations are designed to support highway traffic and are approved by the Department in accordance with N.J.A.C. 16:41 and 16:47. Manholes may be retained or installed under paving on low traffic roadways, less than 750 ADT, within municipalities. Effort should be made to minimize such installations and to avoid their location at street intersections, insofar as practicable. Manholes shall be designed and located in such a manner that will cause the least interference to other utilities and future highway expansion.

5. (No change.)

16:25-3.9 Installation

Installation or replacement of pipelines along or crossing existing highways shall be controlled by end-product specifications. However, safety of traffic and preservation of the earth structure supporting the pavement requires some restriction of methods used in the operation. Conditions of installation, if any, will be specified in the permit. Several acceptable methods of installation are detailed in N.J.A.C. 16:25-3.10, 3.11, and 3.12.

16:25-3.11 Untrenched construction and grouting

(a) Several techniques acceptable to the Department for installing pipelines under a highway without disturbing the surface are as follows:

1.-2. (No change.)

3. Boring: Large pipes can be jacked through oversize bores carved progressively ahead of the leading edge of the advancing pipe as spoil is mucked back through the pipe. Control is excellent. Cutterhead should be sized closely to pipe diameter and pipe should be advanced, with cutterhead in close proximity, to minimize annual void and overbreaks.

4. (No change.)

(b) The required controls for untrenched construction and grouting are as follows:

1.-2. (No change.)

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3. The oversize of the boring excavation shall be restricted and the Department shall establish, case by case, the conditions specified under which the void outside the carrier must be back-filled with grout. Where the soils are favorable and the carrier is four feet or more deep, the boring hole may be five percent oversize in diameter. The Department shall require grout backfill for pipes more than 12 inches in diameter for overbreaks, unused holes, or abandoned pipes.

16:25-3.13 Adjustment

(a) The following are required controls for adjusting existing pipelines that fall in the path of highway construction projects:

1. (No change.)

2. An existing pipeline shall be relocated in plan and/or grade where:

i. (No change.)

ii. The top of the pipe is within 18 inches ***of subgrade*** or determined to be too close to highway grade.

3.-4. (No change.)

5. Notwithstanding reinforcement or protection otherwise provided, the highway construction contractor should be warned and made responsible for the security of each existing pipeline within the construction zone. Where there are unusual utility hazards and where heavy construction equipment will be needed, it should be arranged that the contractor provide a temporary protective cover of each or bridge the utility.

16:25-4.1 General consideration

(a)-(c) (No change.)

(d) Since an encasement is not normally provided for a pipeline attachment to a bridge, additional protective measures shall be taken. Such measures shall employ a higher factor of safety in the design, construction, and testing of the pipeline than would normally be required for cased construction.

(e)-(f) (No change.)

16:25-5.1 General

(a) (No change.)

(b) In an effort to provide a safer environment for the traveling public and to improve the aesthetic qualities of newly designed freeways and land service roadways, above ground utilities are restricted in certain locations as follows:

1. No above ground facilities will be located within grade separated interchange areas of limited access highways.

2. No aerial crossing of limited access highway rights-of-way are permitted with the exception of electrical facilities operating at a potential of 26 KV or above.

16:25-5.2 Type of Construction

(a) Any longitudinal installation of overhead lines on the highway rights-of-way shall be limited to single wooden pole type of construction. The Department shall consider requests to use a non-wooden pole type of construction on a case-by-case basis in accordance with N.J.A.C. 16:25-2.3, only in unusual circumstances in which public safety is not compromised.

(b) Joint-use single pole construction shall be encouraged, as indicated by Rule 222 of the National Electrical Safety Code[1], at locations where more than one utility or type of facility is involved. This is of particular significance at locations where the right-of-way widths approach the minimum needed for safe operations or maintenance requirements or where separate installations may require extensive removal or alterations of trees.

[1](No change.)

16:25-5.3 Clearance

(a) The minimum clearance for overhead power communication lines above the highway and the lateral and vertical clearance from bridges shall in no case be less than the standards prescribed by the National Electrical Safety Code.

(b) (No change.)

(c) The minimum clearances between overhead power lines and highway traffic signals of lighting standards shall be determined by the following:

Power Line Voltages	Minimum Clearances	
	Lateral	Vertical
0-750 volts (secondary)	5 feet	6 feet
750 volts—50 KV (primary)	10 feet	10 feet

Note: Voltages above 50 KV, clearance shall be increased by 0.4 inches per kilovolt.

(d) The minimum clearances between overhead power lines and highway signs, sign standards or sign bridges shall be determined by the following:

Power Line Voltages	Minimum Clearances	
	Lateral	Vertical
0-750 volts (secondary)	5 feet	5 feet
750 volts—8.7 KV (primary)	5 feet	8 feet
8.7 KV—22 KV	6 feet	8 feet
22 KV—50 KV	7 feet	9 feet

Note: Voltages above 50 KV, clearance shall be increased by 0.4 inches per kilovolt.

16:25-5.4 Location

(a) Utility poles shall be located as close to the right-of-way line as practical. In the case of vertical stack construction, desirable pole offset should be three feet from the right-of-way line. Where crossarm construction is utilized, desirable pole offset should be five feet from the right-of-way line. Other offsets may be approved by the Department in accordance with the "New Jersey Department of Transportation Design Manual—Roadway."

(b) For existing urban arterials, urban collectors and local streets where there are curbed sections, utilities may be located in the border areas between the curb and sidewalk, at least 1.5 feet behind the face of curb, and where feasible, behind the sidewalk and as close to the right-of-way line as practical. For non-curbed urban sections, utility poles should be located as close to the right-of-way line as practical.

(c) Consideration should be given to increasing the minimum pole offsets on the outside of horizontal curves, particularly on those curves with a sharper degree of curvature than what are normal for the section of highway involved.

(d) For rural highways with or without curb and where posted speeds are 25 mph or less, poles should be placed as close to the right-of-way line as possible. If the locations of the poles, as stated herein, are infeasible and other mitigating conditions, such as parking or excess are infeasible and other mitigating conditions, such as parking or excess lane width lessen the exposure or potential accident severity, then placement of poles at least 1.5 feet behind the face of curb, edge of through pavement or edge of shoulder, based on engineering judgement can be considered.

16:25-5.5 General considerations

(a) The desirable offset behind guide rail is four feet. See the New Jersey Department of Transportation Design Manual—Roadway for further information.

1. In those cases where poles are set, with less than desirable offset behind guide rail, and said placement requires that the guide rail be modified, the utility owner shall be responsible for modifying, or for the cost of modifying the guide rail for a minimum distance of 12 and one-half feet either side of the pole.

(b) Poles shall always be located behind guide rail wherever same exists and should not be placed longitudinally within 25 feet of the advance of, or after the terminus of, guide rail. Where crash worthy end treatments exist, poles shall be located 50 feet longitudinally behind the guide rail's termini. See New Jersey Department of Transportation Design Manual—Roadway.

(c) Placement of poles in islands that do not have a longitudinal through roadway length of 100 feet or more is discouraged except where other locations are unusually difficult and unreasonably costly.

(d) (No change.)

Recodify existing (f)-(h) as (e)-(g) (No change in text.)

(h) When rebuilding an existing pole line or constructing a new pole line at locations where there is no traffic signal standard, lighting standard, or sign standard, poles of not less than 40 feet

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on overall length shall be installed and the attached primary line, at its lowest point, shall have a minimum clearance of 30 feet from the ground. At locations where a traffic signal standard, lighting standard, or sign standard exists, the criteria shall conform to N.J.A.C. 16:25-5.3.

(i) When electrical facilities (26 KV and above) are approved for installation across limited access highway rights-of-way in accordance with N.J.A.C. 16:25-5.1, they shall be installed in accordance with the criteria outlined in N.J.A.C. 16:25-5.3; however, the proximity criteria used shall take into account not only existing highway facilities (that is, light standards, sign supports, etc.), but also facilities that the Department proposes within the area where the utility crossing will be constructed.

16:25-7.2 Required controls for underground electric power and communication lines

(a) General rules concerning required controls for underground electric power and communication are as follows:

1. (No change.)

2. The Department has established a minimum bury of 36 inches.

3. Pedestals or other above ground utility appurtenances installed as part of buried cable plant shall be located as close to the right-of-way line as possible, or behind guide rail wherever same exists.

4.-5. (No change.)

6. The controls outlined in N.J.A.C. 16:25-4 for electric power and communication line attachments to highway bridge structures shall be followed.

7. The general controls outlined in N.J.A.C. 16:25-3 for pipelines as relate to markers, installations, trenched and untrenched construction, and adjustment shall be followed, as applicable, on underground installations of electric power and communication lines.

(b) (No change.)

(c) Cased and uncased construction shall be as follows:

1.-3. (No change.)

4. Underground construction within grade separated interchange areas of limited access highways shall, at a minimum, extend between the interchanges outermost ramps.

16:25-7A.1 General considerations

(a)-(d) (No change.)

(e) Access to the public utility facilities for the purpose of installation, repair or maintenance shall not be achieved from highway ramps or roadways, but rather from local roads or points outside of the limited access highway's control or access line. Exceptions may be granted in appropriate cases with prior written consent at the discretion of the Commissioner where the Commissioner determines that such exception would be in the public interest. All access shall be achieved in accordance with the Department approved traffic control plan, pursuant to N.J.A.C. 16:41 and N.J.A.C. 16:47, as applicable.

(f)-(i) (No change.)

16:25-7A.3 Locations

(a) Where the Department deems public utility facility installations feasible, the Department will establish, within the right-of-way of limited access highways, a corridor, generally not closer than 30 feet to the edge of roadway, but contiguous to each side of the roadway's control of access line, for the installation of underground utility facilities, with possible exceptions to be granted by the Commissioner, at the Commissioners' sole discretion, where it is determined that the public good justifies an exception. Should such an exception allow a public utility facility to be placed within 15 feet of the edge of pavement, the facility shall be placed within a galvanized steel pipe casing.

(b)-(l) (No change.)

SUBCHAPTER 8. (RESERVED)

16:25-9.4 Multiple use of freeway rights-of-way

(a) (No change.)

(b) When such extreme case need is demonstrated to the satisfaction of the Department as being in the best public interest, and the design, location, and measures for protecting the integrity, operational characteristics, and safety of freeway traffic meet all of the conditions set forth in this chapter, then a joint use and occupancy agreement or permit may be entered into with the utility by the New Jersey Department of Transportation to allow such installations.

SUBCHAPTER 10. PERMITS

16:25-10.1 Application for permit

(a) (No change.)

(b) Such written application shall consist of a complete description of the facility to be installed or constructed, or the work to be performed on an existing facility, and a sketch or plans to scale, no smaller than one inch equals 50 feet, preferably, one inch equals 30 feet, and maximum plansheet size of 24 inch by 36 inch which show the existing and/or proposed location of the facilities within the highway right-of-way in relation to the existing and/or planned highway improvement, the traveled way, the right-of-way lines, and control of access lines and approved access points where applicable. Profile view plans and cross sections shall also be furnished when required for clarity.

(c) (No change.)

(d) All applications shall be made a part of the permit issued by the Regional Maintenance Office and shall be submitted in the number of copies, including plans or sketches, required by N.J.A.C. 16:41 and N.J.A.C. 16:47.

(e) (No change.)

(f) A permit shall expire if all construction work under the permit, including those permits issued under N.J.A.C. 16:41, is not completed within two years of the date the permit was issued, unless stated otherwise in the permit or extended by renewal. When work covered by the permit is started within two years of the date of permit issuance but cannot be completed in the indicated time, the permittee shall request an extension of time in writing from the appropriate Regional Maintenance Office and submit the required renewal fee in the form of a check or money order. The Department may approve one one-year extension, in accordance with N.J.A.C. 16:41, or N.J.A.C. 16:47, as appropriate.

16:25-10.2 Opening permits

(a)-(c) (No change.)

(d) Permits for open-cut should be supervised by the Regional Maintenance Office to assure satisfactory replacement of base course and roadway paving.

SUBCHAPTER 11. SPECIAL PERMITS AND AGREEMENTS

16:25-11.1 Railroad crossings

(a) The Commissioner of Transportation has plenary power over all public railroad crossings in the State, in accordance with N.J.S.A. 48:12-49 et seq.

(b) Railroad crossings consist of grade separated crossings (bridged) and at grade crossings:

The following applies to grade separated crossings:

i. For grade separated crossings where the railroad is over the highway, the Department shall determine the vertical and horizontal under clearances and the railroad and the Department shall approve the structure of the crossing;

ii. For grade separated crossings where the railroad is under the highway, the railroad shall determine the vertical and horizontal under clearances and the Department and railroad shall approve the structure of the crossing;

2. The following applies to at grade crossings:

i. Public at grade crossings occur where the railroad intersects an existing or proposed public street or highway. New public at grade crossings or modifications to existing public at grade crossings are only permitted by the Commissioner of Transportation, after he or she exercises the evaluation, public information and response process delineated in (c) below.

ii. Private at grade crossings occur in areas other than public thoroughfares, and the Commissioner normally does not exercise his or her authority over these crossings; however, where a private at grade crossing is used primarily by the general public, the Com-

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missioner may take jurisdiction of the private at grade crossing if he or she is of the opinion such jurisdiction is in the interest of public safety.

(c) The evaluation, public information and response process for at grade public crossings shall be conducted by the Department as follows:

1. A diagnostic team, composed of Department staff, the applicant for the crossing, and municipal and county officials who have an interest in the crossing, will meet on the site of the proposed crossing to evaluate the engineering and safety aspects of the crossing;

2. The team leader (a Department staff member) will prepare a memorandum of record, noting the findings of the team;

3. The Department will publish a notice in the newspaper(s) serving the area in which the proposed grade crossing is located, describing the particular work intended at the grade crossing, and calling for members of the public who object, or who have questions or comments regarding the proposed crossing to submit their objections, questions or comments to the Department; and

4. The Department will respond to the commenters in writing.

(d) Any person who objects to the Department's decision regarding an at grade crossing may request a hearing, in accordance with the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

16:25-11.2 Local-Federal Aid Agreements

(a) Pursuant to the provisions of Federal-Aid Policy Guide, Title 23, Chapter 1, Subchapter G, Part 645, Subpart B, the Department shall enter into agreements with appropriate county and municipal officials to provide for regulating the use and occupancy of Federal Aid Roads, and to assist local officials in establishing utility accommodation policies conforming, as appropriate for the type of highway involved, to the provisions of this chapter.

(b) Such agreements may be entered into on a project-by-project basis handled by the Bureau of Local Highway Design. Until a county or municipality adopts a utility accommodation policy approved by the Department conforming to federal requirements, the Bureau of Utilities and Railroad Engineering shall review for conformance with the State requirements in effect at the time all utility rearrangement schemes on Federal Aid Roads that are subject to the provisions of Federal-Aid Policy Guide, Title 23, Chapter 1, Subchapter G, Part 645, Subpart B.

16:25-11.3 Private utilities

(a) (No change.)

(b) Where the requested use and occupancy involved more than a road crossing or a relatively short segment of parallel line (for example, up to 1/8 mile), or where equivalent utility service is available without the private line installation, then the request shall be referred to the Office of the Attorney General for an opinion as to whether the proposed private use of the highway right-of-way is in violation of State law. All such private lines must also meet all other applicable provisions of this chapter.

(c) (No change.)

16:25-12.1 Reimbursement basis

(a) Reimbursement to utility owners for required relocations and adjustments of existing utility lines, systems and facilities required by highway construction or improvements shall be made in accordance with the detailed procedures of Federal-Aid Policy Guide Title 23, Chapter 1, Subchapter G, Part 645, Subpart A. As provided in such Federal regulations, the determination of eligibility for reimbursement shall be made pursuant to applicable State law, both statutory and case, and the Constitution; and such basis for determination of eligibility (compensable property interest) under New Jersey law is generally interpreted by legal counsel for the Department and should be administered, as follows:

1. (No change.)

2. Existing public utilities located on the street right-of-way of any incorporated town or city, and which right-of-way was not a part of, or on the State highway system at the time of the installation or construction of the utilities, shall be considered eligible for reimbursement.

3. Existing public utilities located on county road, dedicated urban development road, and/or private road rights-of-way which were not a part of, or on, the State highway system at the time of the installation or construction of the utilities, shall be considered eligible for reimbursement.

4. The installation or construction of extra utility properties (such as, but not limited to, encasement pipes and taller poles) and other extra costs of installing or constructing new utility facilities that will meet highway construction requirements and/or standards, (and when such construction is on approved highway location or alignment and the extra work will effect lower cost utility adjustments by being performed at the time such new utilities are being installed or constructed on private property or non-highway right-of-way on a Commissioner approved and programmed project) shall be considered eligible for reimbursement. Such "preventive" adjustments shall be handled according to the applicable policies and procedures of Federal-Aid Policy Guide Title 23, Chapter 1, Subchapter G, Part 645, Subpart A, and any amendments and supplements thereto.

5. Existing public utilities located on existing State highway right-of-way by statutory grant and/or written consent of the Department shall be considered as eligible for reimbursement.

6. All public utilities, when effected by freeway construction, shall be considered as eligible for reimbursement.

(b)-(d) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Lane Usage
Route I-195 in Monmouth County
Adopted New Rule: N.J.A.C. 16:30-3.8

Proposed: June 21, 1993 at 25 N.J.R. 2651(a).

Adopted: July 26, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: August 5, 1993 as R.1993 d.427, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:1A-44, 27:21 and 39:4-6.

Effective Date: September 7, 1993.

Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:

The Department received comments from Mr. John C. Jennings, Freehold, New Jersey, concerning the rule proposal.

COMMENT: This is a great idea. The signs and lane markings are already in effect. However, the signs say that the shoulder may only be used by Six Flags traffic not any County Route 537 traffic. Wording to include exiting traffic and Six Flags traffic may use shoulder would be more accurate and appropriate especially since the Department installed the signs.

RESPONSE: The sign legends are restricted by two factors. The legend must be short enough for the motorists to read; and the size of the sign. In this case it was not possible to put both legends on the sign. Therefore, "SIX FLAGS" was chosen as it is the major traffic generator.

COMMENT: The action enhances mobility and benefits motorists using I-195 eastbound whether they exit on County Route 537 or not. However, the exit ramp is of insufficient width to handle two westbound exit lanes and one eastbound exit lane. Will adjustments be made to the traffic signal to facilitate the traffic flow at peak times?

RESPONSE: This is an interim improvement until the long range improvements are implemented. The traffic signal is designed to accommodate peak hour traffic with a special preemption feature to facilitate ramp traffic.

COMMENT: Does the Department collect before-and-after data regarding traffic volumes per lane, travel times and delays, air quality

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impacts, number and severity of accidents and number of summonses and fines levied? This type of data may help determine the efficacy of such actions at other key congested interchanges.

RESPONSE: No. Reduced staffing precludes this type of study.

COMMENT: Will the lane markings and signs be covered after September 30 to prevent driver confusion between October 1 and April 30?

RESPONSE: The signs will be removed and installed annually.

Full text of the adoption follows:

16:30-3.8 Route I-195 shoulder use lanes

(a) The shoulder of State highway I-195, eastbound, from approximately milepost 12 to milepost 16.6, shall be designated and established as a travel lane from 9:00 A.M. to 6:00 P.M., Monday through Sunday, from May 1 through September 30 of each year.

(b) The left lane at Interchange 16 shall be reserved for through traffic only, and no vehicles shall exit from the left lane at Interchange 16, between 9:00 A.M. and 6:00 P.M., Monday through Sunday, from May 1 through September 30 of each year.

(c) In accordance with N.J.S.A. 34:4-199, proper signs shall be erected to inform motorists of the time and dates when this rule is in effect.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping

Routes N.J. 7 in Essex County; U.S. 9 in Atlantic County; N.J. 47 in Cumberland County; N.J. 77 in Cumberland County; N.J. 173 in Hunterdon County; and U.S. 206 in Mercer County

Adopted Amendments: N.J.A.C. 16:28A-1.6, 1.7, 1.33, 1.41, 1.52 and 1.57

Proposed: June 21, 1993 at 25 N.J.R. 2649(a).

Adopted: July 26, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: August 5, 1993 as R.1993 d.426, **without change, but with N.J.A.C. 16:28A-1.41(f)1ii(1)(B) not adopted at this time.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-197.5, 39:4-198 and 39:4-199.

Effective Date: September 7, 1993.

Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:

No comments received.

In reviewing the proposal, the Department discovered that the reference in proposed N.J.A.C. 16:28A-1.41(f)1ii(1)(B) to "124.95 feet" was the result of a number transposition error in the original proposed document. The figure should be "142.95 feet." As such error is substantive, the Department is correcting it through a notice of administrative correction published elsewhere in this issue of the New Jersey Register, and extending the public comment period on the corrected subparagraph to September 7, 1993 through that notice. In the text of N.J.A.C. 16:28A-1.41 adopted herein, subparagraph (f)1ii(1)(B) is shown as "(Reserved.)".

Full text of the adoption follows (addition indicated in boldface with asterisks ***thus***):

16:28A-1.6 Route 7

(a)-(c) (No change.)

(d) The certain parts of State highway Route 7 described in this subsection shall be designated and established as "time limit parking" zones, where parking is prohibited except as specified. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established time limit parking zones:

1. In Essex County:

i. Nutley Township:

(1) Two hours time limit parking from 8:00 A.M. to 6:00 P.M. Sunday through Saturday along both sides (Washington Avenue) from Hancox Avenue to Centre Street.

(2) Two hours time limit parking from 8:00 A.M. to 6:00 P.M. Sunday through Saturday along both sides (Washington Avenue) from Park Avenue to Nutley Avenue.

16:28A-1.7 Route U.S. 9

(a) The certain parts of State highway Route U.S. 9 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times, except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. Stopping or standing along both sides for the entire length within the corporate limits of the following municipalities shall be prohibited, including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation, except in areas covered by other parking restrictions.

i. (No change.)

ii. Atlantic County:

(1)-(4) (No change.)

(5) Absecon City;

(6) Port Republic City; and

(7) Galloway Township.

iii.-vi. (No change.)

(b)-(c) (No change.)

16:28A-1.33 Route 47

(a) The certain parts of State highway Route 47 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times, except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. (No change.)

2. No stopping or standing in Cumberland County:

i. (No change.)

ii. In the City of Vineland:

(1) Along both sides:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation, except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30.

3.-10. (No change.)

(b)-(c) (No change.)

16:28A-1.41 Route 77

(a)-(d) (No change.)

(e) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "no parking certain hours" zones. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following zones:

1. No parking certain hours in Cumberland County:

i. In the City of Bridgeton:

(1) Along the southbound (west side):

(A) From 7:00 A.M. to 12:00 noon on Tuesday between Washington Street and Melford Drive.

(2) Along the northbound (east side):

(A) From 7:00 A.M. to 12:00 noon Monday between Washington Street and Melford Drive.

(f) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "Time Limit Parking" zones where parking is prohibited at all times except as specified

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below in this subsection. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following time limit zones:

1. In the City of Bridgeton, Cumberland County:

i. Two hours time limit parking from 6:00 A.M. to 9:00 P.M. Monday through Saturday:

(1) Along the southbound (west) side:

(A) Beginning at a point 108.57 feet south of the southerly curb line of Washington Street to a point 305.57 feet south of the southerly curbline of Washington Street.

(B) Beginning at a point 65.70 feet south of the southerly curb line of Church Lane to a point 140.70 feet south of the southerly curb line of Church Lane.

(C) Beginning at a point 164.95 feet south of the southerly curb line of East Commerce Street to a point 233.95 feet south of the southerly curb line of East Commerce Street.

(2) Along the northbound (east) side:

(A) Beginning at a point 105.00 feet north of the northerly curb line of Route N.J. 49 to a point 180.00 feet north of the northerly curb line of Route N.J. 49.

(B) Beginning at a point 59.77 feet south of the southerly curb line of McCormick Place to a point 108.77 feet south of the southerly curb line of McCormick Place.

(C) Beginning at a point 90.00 feet north of the northerly curb line of McCormick Place to a point 140.00 feet north of the northerly curb line of McCormick Place.

(D) Beginning at a point 122.00 feet north of the northerly curb line of East Commerce Street to a point 167.00 feet north of the northerly curb line of East Commerce Street.

(E) Beginning at a point 261.00 feet north of the northerly curb line of East Commerce Street to a point 444.00 feet north of the northerly curb line of East Commerce Street.

ii. Fifteen minutes time limit parking from 6:00 A.M. to 9:00 P.M. Monday through Saturday.

(1) Along the southbound (west) side:

(A) Beginning at a point 40.00 feet south of the southerly curb line of Church Lane and extending 25.00 feet south therefrom.

(B) ***(Reserved)***

(C) Beginning at a point 50.00 feet north of the northerly curb line of McCormick Place and extending 25.00 feet north therefrom.

(2) Along the northbound (east) side:

(A) Beginning at a point 35.77 feet south of the southerly curb line of McCormick Place and extending 24.00 feet south therefrom.

(B) Beginning at a point 140.00 feet north of the northerly curb line of McCormick Place and extending 24.00 feet north therefrom.

(C) Beginning at a point 100.00 feet north of the northerly curb line of East Commerce Street and extending 22.00 feet north therefrom.

16:28A-1.52 Route 173

(a) The certain parts of State highway Route 173 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs must be erected.

1.-5. (No change.)

(b) The certain parts of State highway Route 173 described in this subsection shall be designated and established as "no parking bus stop" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1. (No change.)

(c) The certain parts of State highway Route 173 described in this subsection shall be designated and established as "time limit parking" zones where parking is prohibited except as specified below. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs in the following established time limit parking zones:

1. In Bethlehem Township, Hunterdon County:

i. Two hours time limit parking, 24 hours a day, seven days a week for the entire Rest Area within the Jugtown Mountain Rest Area confines.

16:28A-1.57 Route U.S. 206

(a) (No change.)

(b) The certain parts of State highway Route U.S. 206 described in this subsection shall be designated and established as "no parking bus stop zones" where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1. (No change.)

2. Along the westerly (southbound) side in Lawrence Township, Mercer County:

i.-ii. (No change.)

iii. Near side bus stops:

(1)-(8) (No change.)

(9) Lawn Park Avenue—Beginning at the northerly curb line of Lawn Park Avenue and extending 105 feet northerly therefrom.

3.-12. (No change.)

(c) (No change.)

(d) The certain parts of State highway Route U.S. 206 described in this subsection shall be designated and established as a "restricted parking space" for the use of persons who have been issued special Vehicle Identification Cards by the Division of Motor Vehicles. No other persons shall be permitted in these areas. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following parking spaces:

1. Restricted parking space in Lawrence Township, Mercer County:

i. Along the west side (Brunswick Avenue) southbound, in front of 1007 Brunswick Avenue:

(1) Beginning at a point 70 feet north of the northerly curb line of Spruce Street and extending 23 feet northerly therefrom.

TREASURY-GENERAL

(a)

STATE INVESTMENT COUNCIL

State of New Jersey Cash Management Fund Permissible Investments

Adopted Amendment: N.J.A.C. 17:16-61.5

Proposed: July 6, 1993 at 25 N.J.R. 2839(a).

Adopted: August 5, 1993 by the State Investment Council, Roland M. Machold, Director, Division of Investment.

Filed: August 5, 1993 as R.1993 d.425, **without change.**

Authority: N.J.S.A. 52:18A-91.

Effective Date: September 7, 1993.

Expiration Date: May 2, 1996.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

17:16-61.5 Permissible investments

The Director may invest the assets of the State of New Jersey Cash Management Fund in fixed-income and debt securities which are legal investments for savings banks, or which are permitted under the provisions of N.J.S.A. 52:18A-89, subject to any applicable provisions of the regulations of the State Investment Council. All investments in the fund shall mature or are to be redeemed within one year, except that up to 25 percent of the fund may be invested in eligible securities which mature within two years; provided, however, that the average maturity of all investments in the fund shall not exceed one year.

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OTHER AGENCIES

(a)

CASINO CONTROL COMMISSION

Applications
Forms
Gaming School License Standards
Adopted New Rules: N.J.A.C. 19:41-5.1 through 5.10
Adopted Repeal: N.J.A.C. 19:41-7.14
Adopted Amendment: N.J.A.C. 19:44-3.2

Proposed: June 21, 1993 at 25 N.J.R. 2655(a).

Adopted: August 4, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: August 9, 1993 as R.1993 d.429, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 5:12-63c, 69a, 70a, 82, 84, 85, 89b, 90b, 91b, 92, 95.12 and 102b-c.

Effective Date: September 7, 1993.

Operative Date for N.J.A.C. 19:41-5.1 through 5.5: December 1, 1993.

Operative Date for N.J.A.C. 19:41-5.7 through 5.10: October 1, 1993.

Expiration Date: April 15, 1995, N.J.A.C. 19:41;
December 15, 1996, N.J.A.C. 19:44.

Summary of Agency-Initiated Changes:

As proposed, N.J.A.C. 19:41-5.2(b)2 through 4, 5.3(b)2 through 4, 5.4(b)2 through 4 and 5.5(b)2 through 4 cited various documents and other items to be provided by an applicant in conjunction with the filing of a Personal History Disclosure Form (PHDF) as part of the complete application process. The Commission has determined that such provisions should not be codified in the forms rules adopted herein because they are separate documents, not information requested on the forms and will therefore be included in future rulemaking which will provide a more comprehensive outline of the application process.

Summary of Public Comments and Agency Responses:

Comments were received from the Division of Gaming Enforcement ("Division") and Caesar's Atlantic City ("Caesar's").

COMMENT: The Division suggests that N.J.A.C. 19:41-5.2(a)18vii be recodified under N.J.A.C. 19:41-5.2(a)19.

RESPONSE: The Commission agrees and has recodified the provision upon adoption.

COMMENT: The Division inquired whether N.J.A.C. 19:41-5.2(a)10 correctly describes the employment data requested in the PHD-1A for the applicant's family, or whether that question is limited to current employment only.

RESPONSE: N.J.A.C. 19:41-5.2(a)10, as proposed, accurately reflects the employment data requested in the PHD-1A.

COMMENT: The Division comments that N.J.A.C. 19:41-5.8(a)10i, consistent with the other questions stated, should indicate that the Business Entity Disclosure Form—Holding Company (BED-HC) includes a sole proprietor.

RESPONSE: Such reference was inadvertently omitted from proposed N.J.A.C. 19:41-5.8(a)10i and is added upon adoption for consistency.

COMMENT: Caesar's questions whether certain information requested in the disclosure forms is "warranted by legitimate law enforcement concerns." Caesar's objects to the following as "irrelevant to the qualifications of the applicant": N.J.A.C. 19:41-5.2(a)10 and 5.2(a)20 (employment data and financial data for the applicant's spouse and children); N.J.A.C. 19:41-5.2(a)14 and 5.2(a)16 (data for the applicant's spouse regarding trusteeships or fiduciary positions, professional or occupational licenses, motor vehicle information and licenses and other approvals issued by a government agency); N.J.A.C. 19:41-5.2(a)15 (current memberships in any social, labor or fraternal union, club or organization); N.J.A.C. 19:41-5.1(a)16iii (firearms permit); N.J.A.C. 19:41-5.2(a)20viii-xi (beneficiaries; positions in an estate or trust; bonding); and N.J.A.C. 19:41-5.2(a)20xviii (leasing arrangements, trading in foreign currencies and the sale of purchases of commercial paper by the applicant and any entity for which he or she was a director, officer or a holder of a five percent or greater interest).

RESPONSE: As the proposal noted (see 25 N.J.R. 2655(a)), the new rules describe recently updated disclosure forms, the product of an extensive review process conducted by the Commission and the Division. While the revision process seeks, to the extent possible, to achieve simple and concise disclosure forms, it is essential that applicants provide the regulatory agencies with adequate initial information to commence the comprehensive investigation necessary for an informed decision on their fitness for licensure or qualification.

The PHD-1A form cited by the commenter is filed by those who must establish their qualifications by virtue of their relationship with a casino applicant or licensee (see N.J.S.A. 5:12-82b, 82c, 84b, 85c, 85d, 85e and 95) or with a gaming-related casino service industry applicant or licensee (see N.J.S.A. 5:12-92a and 92b). The high standards of good character, honesty and integrity required by the Act of such persons dictate that such form seek the most comprehensive and detailed disclosure. While certain questions pertain specifically to the applicant, a thorough investigation of the applicant's background necessarily requires broader inquiry. Some of the questions cited by the commenter, for example, financial data for the applicant's spouse, are essential to complete an accurate assessment of the applicant's status. Other data, such as information regarding firearms permits held or applied for, can provide a useful law enforcement resource for investigative purposes.

COMMENT: Caesar's objects to N.J.A.C. 19:41-5.2(a)17, stating that the provision "singles out" employment in connection with an alcoholic beverage operation and that "there is nothing illegal about employment with that type of entity." Caesar's likewise questions N.J.A.C. 19:41-5.2(a)19, arguing that "corporate contributions to state and local elections are frequently legal" and that the data requested should be limited to illegal political contributions. Similarly, in reference to N.J.A.C. 19:41-5.2(a)20x, Caesar's comments that "there is nothing improper about establishing a trust or inheriting an estate."

RESPONSE: These questions have broader relevance than the commenter implies, and their inclusion is not intended to suggest that the activities disclosed are inherently illegal or "improper." N.J.A.C. 19:41-5.2(a)17 requests information regarding two highly regulated industries, gaming and alcoholic beverages, and as such provides a useful law enforcement resource for purposes of investigation.

COMMENT: Caesar's finds some questions duplicative and suggests the addition of greater detail. In particular, Caesar's seeks greater specificity in differentiating between the data requested in N.J.A.C. 19:41-5.2(a)13 (government positions and offices and offices, trusteeships, directorships or fiduciary positions), N.J.A.C. 19:41-5.2(a)14 (trusteeships or fiduciary positions held by the applicant and the applicant's spouse) and N.J.A.C. 19:41-5.2(a)10 (employment). Similarly, Caesar's sees the need for more detail in N.J.A.C. 19:41-5.2(a)18 to clarify the terms "unindicted party" in a criminal proceeding and appearance before a "committee," and to set forth limitations on the data requested regarding juvenile offenses.

RESPONSE: In reading the new rules, the commenter must remain cognizant that the purpose of the proposal is not to provide a verbatim transcription of the questions as they appear in each form. Clearly, nothing short of an actual reproduction of every disclosure form would provide the fully comprehensive, detailed questions as stated in the forms. Rather, the new rules provide a general description of the data that an applicant or qualifier is requested to provide. The commenter may wish to refer to the actual PHD-1A, available from the Commission's Division of Licensing.

COMMENT: Caesar's comments that N.J.A.C. 19:41-5.2(a)16v, regarding any denial, suspension or revocation of a license, is duplicative of N.J.A.C. 19:41-5.2(a)16i and should be clarified.

RESPONSE: As is apparent, N.J.A.C. 19:41-5.2(a)16i expressly refers only to a "professional or occupational license", while that which is sought in N.J.A.C. 19:41-5.2(a)16v includes "licenses, permits and certifications" of all kinds issued by a governmental agency.

COMMENT: Caesar's objects to the data request in N.J.A.C. 19:41-5.2(a)16v, regarding any denial, suspension or revocation of a license, permit or certification held by or applied for by any entity in which the applicant or his or her spouse was a director, officer, partner or an owner of a five percent or greater interest. Caesar's comments that an officer of a substantial entity may not have personal knowledge of answers to such question.

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RESPONSE: An applicant or qualifier filing any disclosure form has a duty to respond to the questions therein to the best of his or her knowledge and belief.

COMMENT: Caesar's contends that the codification of the Business Entity Disclosure Form-3 ("BED-3"), in particular, N.J.A.C. 19:41-5.7(a)13i, will infringe upon the Commission's discretion in determining which officers and directors of a "major enterprise" filing a BED-3 must file a Qualifier Disclosure Form.

RESPONSE: The new rules simply describe the questions asked in the BED-3 and each of the other disclosure forms, thereby codifying the content of the forms. The new rules do not attempt to address the issues of which persons are required to file any of the codified forms; while this may be the subject of future rulemaking, it is beyond the limited scope of this proposal.

COMMENT: Caesar's comments that the proposal does not deal with renewals, which it suggests should be dealt with "in a consistent, predictable manner."

RESPONSE: Such topic is beyond the scope of the proposal, which codifies those Personal History Disclosure forms filed by applicants for initial casino key employee and initial casino employee licensure, applicants for casino hotel employee registration, qualifiers of casino licensees or applicants, and qualifiers of gaming-related casino service industry applicants.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 5. FORMS

19:41-5.1 Definitions

The following words and terms shall have the following meanings when used in this subchapter, unless the context clearly indicates otherwise.

"Family" is defined at N.J.A.C. 19:40-1.2.

"Immediate family" means a person's spouse and any children, whether by marriage, adoption or natural relationship.

19:41-5.2 Personal History Disclosure Form 1A (Casino Key Employee/Qualifier Form)

(a) A Personal History Disclosure Form 1A (Casino Key Employee/Qualifier Form or PHD-1A) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Name, including any aliases or nicknames;
2. Date of birth;
3. Physical description;
4. Current address and residence history;
5. Social security number, which information is voluntarily provided in accordance with section 7 of the Privacy Act, 5 U.S.C. 552a;
6. Citizenship and, if applicable, information regarding resident alien status;
7. Marital history, dependents and other family data;
8. The casino licensee or applicant, casino service industry enterprise licensee or applicant or holding company, as applicable, with which the applicant is affiliated, and the nature of the applicant's position with or interest in such entity;
9. Telephone number at current place of employment;
10. Employment history of the applicant and the applicant's immediate family;
11. Education and training;
12. Record of military service;
13. Government positions and offices presently or previously held, and offices, trusteeships, directorships or fiduciary positions presently or previously held with any business entity;
14. Trusteeships or other fiduciary positions held by the applicant and the applicant's spouse, and any denial or suspension of, or removal from, such positions;
15. Current memberships in any social, labor or fraternal union, club or organization;
16. Licenses and other approvals held by or applied for by the applicant or, where specified, the applicant's spouse, in this State or any other jurisdiction, as follows:

i. Any professional or occupational license held by or applied for by the applicant or the applicant's spouse;

ii. Motor vehicle registrations and operator licenses held by or applied for by the applicant or the applicant's spouse, and any revocation or suspension thereof;

iii. Possession or ownership of any pistol or firearm, or any application for any firearm permit, firearm dealer's license, or permit to carry a pistol or firearm;

iv. Any license, permit, approval or registration required to participate in any lawful gambling operation in this State or any jurisdiction held by or applied for by the applicant; and

v. Any denial, suspension or revocation by a governmental agency of a license, permit or certification held by or applied for the applicant or the applicant's spouse, or any entity in which the applicant or the applicant's spouse was a director, officer, partner or an owner of a five percent or greater interest;

17. Any interest in or employment presently or previously held by the applicant with an entity which has applied for a permit, license, certificate or qualification in connection with any lawful gambling or alcoholic beverage operation in this State or any other jurisdiction; and any current employment or other association by the applicant's immediate family with the gambling or alcoholic beverage industries in this State or any other jurisdiction;

18. Civil, criminal and investigatory proceedings in any jurisdiction, as follows:

i. Arrests, charges or offenses committed by the applicant or any member of the applicant's immediate family;

ii. Any instance where the applicant has been named as an unindicted party or co-conspirator in a criminal proceeding or held as a material witness;

iii. Any appearance before, investigation by or request to take a polygraph examination by any governmental agency, court, committee, grand jury or investigatory body, and any refusal to comply with a request to do so;

iv. Lawsuits to which the applicant was or is a party;

v. Any citation or charge for a violation of a statute, regulation or code of any jurisdiction, other than a criminal, disorderly persons, petty disorderly persons or motor vehicle violation; ***and***

vi. Any use, distribution, or possession of any narcotic, hallucinogenic, drug, barbiturate, amphetamine or other substance listed in Schedule I through V of N.J.S.A. 2C:35-5 et seq. other than pursuant to a valid prescription issued by a licensed physician; *[and]*

[vii. Whether any entity in which the applicant has been a director, officer, principal employee or a holder of more than five percent interest, has made bribes or kickbacks to any government official; maintained a bank account or other account not reflected on the books or records of the business; or maintained a bank account in a name other than the name of the business;]

19. Whether any entity in which the applicant has been a director, officer, principal employee or a holder of more than five percent interest has***:***

i. *[donated]* ***Donated*** or used funds or property for the use or benefit of or in opposing any government, political party, candidate or committee;

ii. *[compensated]* ***Compensated*** its directors, officers or employees for time and expenses incurred in performing services for benefit of or in opposing any government or political party; *[or]*

iii. *[made]* ***Made*** any loans, donations or other disbursements to its directors, officers or employees for the purpose of making political contributions or reimbursing such individuals for political contributions; *[and]*

iv. Made bribes or kickbacks to any government official; or

v. Maintained a bank account or other account which is not reflected on the books or records of the business or which is in a name other than the name of the business; and

20. Financial data, as follows:

i. All assets and liabilities of the applicant, and the applicant's spouse and dependent children as indicated on the net worth statement and supporting schedules in a format prescribed by the Commission, including cash, bank accounts, notes payable and receivable,

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real estate and income taxes payable, loans, accounts payable and any other indebtedness, contingent liabilities, securities, real estate interests, real estate mortgages and liens, life insurance, pension funds, vehicles and other assets;

ii. Bank accounts, including any right of ownership in, control over or interest in any foreign bank account, and safe deposit boxes;

iii. Real estate interests held by the applicant or the applicant's spouse or dependent children;

iv. Businesses owned;

v. Copies of Federal tax returns and related information;

vi. Judgments or petitions for bankruptcy or insolvency concerning the applicant or any business entity in which the applicant held a five percent or greater interest, other than a publicly traded corporation, or in which the applicant served as an officer or director;

vii. Any garnishment or attachment of wages, charging order or voluntary wage execution, including the amount, court, nature of the obligation and the holder of the obligation;

viii. Executors and beneficiaries of the applicant's Last Will and Testament;

ix. Life insurance policies on the applicant's life which name someone other than the applicant's family as a beneficiary;

x. Positions held or interest received in any estate or trust;

xi. Whether the applicant has ever been bonded for any purpose or been denied any type of bond, including the nature of the bond and if applicable, the reason for denial;

xii. Insurance claims in excess of $100,000 by the applicant or the applicant's spouse or dependent children;

xiii. Referral or finder's fees in excess of $10,000;

xiv. Loans in excess of $10,000 made or received by the applicant, the applicant's spouse or dependent children;

xv. Gifts in excess of $10,000 given or received by the applicant or the applicant's immediate family;

xvi. Brokerage or margin accounts with any securities or commodities dealer;

xvii. Currency exchanges in an amount greater than $10,000;

xviii. Information regarding any instance where the applicant or any entity in which the applicant was a director, officer or holder of a five percent or greater interest has traded in foreign currencies or in a foreign commodities exchange, sold or purchased discounted promissory notes or other commercial paper, or been a party to any leasing arrangements in excess of $50,000; and

xix. Information regarding any ownership interest or financial investment by the applicant in any entity which holds or is an applicant for a license issued by the Commission, or in any gambling venture which does not require licensure by the Commission, including persons providing or reasonably anticipated to provide the applicant with support in the financing of such investment or interest; the extent and nature of the applicant's involvement in the management and operation of the entity; whether the applicant has or has agreed to assign, pledge or hypothecate such interest or investment, the nature and terms of any such transaction and a copy of any such agreement.

(b) In addition to the information in (a) above, a completed PHD-1A may include the following:

1. The name, address, occupation and phone number of persons who can attest to the applicant's good character, reputation and business ability;

*[2. A copy of the applicant's birth certificate or, if a birth certificate is not available, one of the following:

i. A certificate of baptism;

ii. A notarized affidavit, in a form prescribed by the Commission, stating the date and place of birth, and two forms of identification which specify the applicant's date of birth; or

iii. Naturalization papers;

3. An original photograph of the applicant taken within the previous 12 months;

4. An identification number provided by the Division of Gaming Enforcement at the time the applicant is fingerprinted;]*

*[5.]***2.*** A signed, dated and notarized certification of truth; and

*[6.]***3.*** A signed, dated and notarized Release Authorization which shall direct all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division.

19:41-5.3 Personal History Disclosure Form 1B (Basic Key Form)

(a) A Personal History Disclosure Form 1B (Basic Key Form or PHD-1B) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Name, including any aliases or nicknames;

2. Date of birth;

3. Physical description;

4. Current address and residence history;

5. Social security number, which information is voluntarily provided in accordance with section 7 of the Privacy Act, 5 U.S.C. 552a;

6. Citizenship and, if applicable, information regarding resident alien status;

7. Position endorsement selection;

8. Marital history and other family data;

9. Telephone number at current place of employment;

10. Employment history, including any gaming-related employment;

11. Education and training;

12. Record of military service;

13. Licenses and other approvals held by or applied for by the applicant or, where specified, the applicant's spouse, in this State or any other jurisdiction, including:

i. Any license, permit, approval or registration required to participate in any lawful gambling operation in this State or any jurisdiction;

ii. Any denial, suspension or revocation by a government agency in this State or any other jurisdiction of a license, permit or certification held by or applied for by the applicant or the applicant's spouse;

iii. Motor vehicle registrations and operator licenses held by or applied for by the applicant or the applicant's spouse, and any revocation or suspension thereof;

14. Civil, criminal and investigatory proceedings in any jurisdiction, as follows:

i. Arrests, charges or offenses committed by the applicant or any member of the applicant's immediate family;

ii. Any appearance before, investigation by or request to take a polygraph examination by any governmental agency, court, committee, grand jury or investigatory body; and

iii. Lawsuits to which the applicant was or is a party; and

15. Financial data, as follows:

i. All assets and liabilities of the applicant, and the applicant's spouse and dependent children as indicated on the net worth statement and supporting schedules in a format prescribed by the Commission, including cash, bank accounts, notes payable and receivable, real estate and income taxes payable, loans, accounts payable and any other indebtedness, contingent liabilities, securities, real estate interests, real estate mortgages and liens, life insurance, pension funds, vehicles and other assets;

ii. Bank accounts, including any right of ownership in, control over or interest in any foreign bank account, and safe deposit boxes;

iii. Real estate interests held by the applicant or the applicant's spouse or dependent children;

iv. Businesses owned;

v. Copies of Federal tax returns and related information;

vi. Judgments or petitions for bankruptcy or insolvency concerning the applicant or any business entity in which the applicant held a five percent or greater interest, other than a publicly traded corporation, or in which the applicant served as an officer or director;

vii. Any garnishment or attachment of wages, charging order or voluntary wage execution, including the amount, court, nature of the obligation and the holder of the obligation;

viii. Executors and beneficiaries of the applicant's Last Will and Testament;

ix. Positions held or interest received in any estate or trust;

x. Insurance claims in excess of $100,000 by the applicant or the applicant's spouse or dependent children;

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xi. Loans in excess of $10,000 made or received by the applicant, the applicant's spouse or dependent children;

xii. Gifts in excess of $10,000 given or received by the applicant or the applicant's immediate family; and

xiii. Referral or finder's fees in excess of $10,000.

(b) In addition to the information in (a) above, a completed PHD-1B may included the following:

1. The name, address, occupation and phone number of persons who can attest to the applicant's good character, reputation and business ability;

*[2. A copy of the applicant's birth certificate or, if a birth certificate is not available, one of the following:

i. A certificate of baptism;

ii. A notarized affidavit, in a form prescribed by the Commission, stating the date and place of birth, and two forms of identification which specify the applicant's date of birth; or

iii. Naturalization papers;

3. An original photograph of the applicant taken within the previous 12 months;

4. An identification number provided by the Division of Gaming Enforcement at the time the applicant is fingerprinted;]*

*[5.]**2.** A signed, dated and notarized certification of truth; and

*[6.]**3.** A signed, dated and notarized Release Authorization which shall direct all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division.

19:41-5.4 Personal History Disclosure Form 2A (Casino Employee License Application)

(a) A Personal History Disclosure Form 2A (Casino Employee License Application or PHD-2A) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Name, including any aliases or nicknames;

2. Date of birth;

3. Physical description;

4. Current address and residence history;

5. Social security number, which information is voluntarily provided in accordance with section 7 of the Privacy Act, 5 U.S.C. 552a;

6. Citizenship, and if applicable, resident alien status;

7. Position endorsement selection;

8. Marital history;

9. Telephone number at current place of employment;

10. Employment history, including any gaming-related employment;

11. Education and training;

12. Record of military services;

13. Licenses of other approvals held by or applied for by the applicant in this State or any other jurisdiction, including:

i. Any license, permit, approval or registration required to participate in any lawful gambling operation;

ii. Any denial, suspension or revocation by a government agency of a license, permit or certification; and

iii. Motor vehicle registrations and operator licenses and any revocation or suspension thereof;

14. Civil, criminal and investigatory proceedings in any jurisdiction, as follows:

i. Arrests, charges or offenses committed by the applicant or any member of the applicant's immediate family;

ii. Any appearance before, investigation by or request to take a polygraph examination by any governmental agency, court, committee, grand jury or investigatory body; and

iii. Lawsuits to which the applicant was or is a party; and

15. Financial data, as follows:

i. Businesses owned;

ii. Bank accounts and safe deposit boxes;

iii. Judgments or petitions for bankruptcy or insolvency concerning the applicant, including a copy of the bankruptcy petition and discharge, if granted, and any such judgment or petition concerning any business entity in which the applicant held a five percent or greater interest, other than a publicly traded corporation, or in which the applicant served as an officer or director; and

iv. Any garnishment or attachment of wages, charging order or voluntary wage execution, including the amount, court, nature of the obligation and the holder of the obligation.

(b) In addition to the information in (a) above, a completed PHD-2A may include the following:

1. The name, address, occupation and phone number of persons who can attest to the applicant's good character, reputation and business ability;

*[2. A copy of the applicant's birth certificate or, if a birth certificate is not available, one of the following:

i. A certificate of baptism;

ii. A notarized affidavit, in a form prescribed by the Commission, stating the date and place of birth, and two forms of identification which specify the applicant's date of birth; or

iii. Naturalization papers;

3. An original photograph of the applicant taken within the previous 12 months;

4. An identification number provided by the Division of Gaming Enforcement at the time the applicant is fingerprinted;]*

*[5.]**2.** A signed, dated and notarized certification of truth; and

*[6.]**3.** A signed, dated and notarized Release Authorization which shall direct all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division.

19:41-5.5 Personal History Disclosure Form 4A (Casino Hotel Employee Registration Application)

(a) A Personal History Disclosure Form 4A (Casino Hotel Employee Registration Application or PHD-4A) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Name, including any aliases or nicknames;

2. Date of birth;

3. Physical description;

4. Current address and residence history;

5. Social security number, which information is voluntarily provided in accordance with section 7 of the Privacy Act, 5 U.S.C. 522a;

6. Citizenship and, if applicable, resident alien status;

7. Marital history;

8. Employment history, including any gaming-related employment;

9. Any license, permit, approval or registration held by or applied for by the applicant and required to participate in any lawful gambling operation in this State or any other jurisdiction; and

10. Arrests, charges or offenses committed by the applicant or any member of the applicant's immediate family;

(b) In addition to the information in (a) above, a completed PHD-4A may include the following:

1. The name, address and phone number of personal references;

*[2. A copy of the applicant's birth certificate or, if a birth certificate is not available, one of the following:

i. A certificate of baptism;

ii. A notarized affidavit, in a form prescribed by the Commission, stating the date and place of birth, and two forms of identification which specify the applicant's date of birth; or

iii. Naturalization papers;

3. An original photograph of the applicant taken within the previous 12 months;

4. An identification number provided by the Division of Gaming Enforcement at the time the applicant is fingerprinted;]*

*[5.]**2.** A signed, dated and notarized certification of truth; and

*[6.]**3.** A signed, dated and notarized Release Authorization which shall direct all courts, probation departments, selective service boards, employers, educational institutions, financial and other in-

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stitutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division.

19:41-5.6 (Reserved)

19:41-5.7 Business Entity Disclosure Form 3

(a) A Business Entity Disclosure Form 3 (BED-3) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Any official or trade name used by the applicant;

2. Whether the application is for initial licensure or renewal and, if a renewal, the license number and expiration date of the current license;

3. The name and telephone number of a person to be contacted in reference to the application;

4. Current or former business addresses of the applicant enterprise;

5. The business form of the enterprise, and a copy of the certificate of incorporation, charter, by-laws, partnership agreement, trust agreement or other basic documentation of the enterprise;

6. The nature of the applicant's business, and the type of goods and services being provided to the casino industry;

7. The following information regarding agreements with any casino licensee or applicant:

i. The number of written agreements entered into and a sample copy of such an agreement;

ii. The terms of any unwritten agreements with casino licensees or applicants, including the expected duration and compensation; and

iii. Whether any such agreements are in any way subject to or conditioned upon any other agreement between the casino licensee or applicant and the applicant or any other enterprise, or upon other agreements between the applicant and its suppliers, vendors or subcontractors, and the facts related thereto;

8. Any suppliers, vendors or subcontractors of the applicant which are also securities holders or creditors of the applicant;

9. The name and location of any government agency in this State or any other jurisdiction that regulates the applicant, and the nature and extent of regulation;

10. Whether the applicant has had any license or certificate denied, suspended or revoked by any government agency in this State or any other jurisdiction, the nature of such license or certificate, the agency and its location, the date of such action, the reasons therefore and the facts related thereto;

11. The following financial information:

i. Two copies of the applicant's most recent financial statement and Federal and state tax returns;

ii. Information regarding any judgments or petitions for bankruptcy or insolvency and any relief sought under any provision of the Federal Bankruptcy Act or any state insolvency law; and any receiver, fiscal agent, trustee or similar officer appointed for the applicant's property or business;

12. Civil, criminal and investigatory proceedings in any jurisdiction, as follows:

i. Information regarding any indictment, charge or conviction for any criminal or disorderly persons offense;

ii. Any criminal proceeding in which the applicant has been a party or has been named as an unindicted co-conspirator; and

iii. Any judgment, consent decree or consent order entered against the applicant pertaining to a violation or alleged violation of the Federal antitrust, trade regulation or securities laws or similar laws of any jurisdiction; and

13. The name, home address, date of birth, title or position and percent of ownership, where applicable, of each of the following persons or entities:

i. Any officer, director, trustee, partner or sole proprietor;

ii. Each beneficial owner, whether an enterprise or a natural person, of more than five percent of the outstanding voting securities of the applicant;

iii. Each sales representative or other person who regularly solicits business from a casino licensee or applicant, such person's immediate supervisors and all persons responsible for the office out of which such supervisors work; and

iv. Any person authorized to sign any agreement with a casino licensee or applicant.

(b) In addition to the information in (a) above, a completed BED-3 may include the following:

1. A certification of truth, which shall be dated, notarized and signed by the following:

i. If the applicant is a corporation, the president or any other authorized officer;

ii. If the applicant is a partnership, each partner;

iii. If the applicant is a limited partnership, each general partner;

iv. If the applicant is a sole proprietorship, the sole proprietor; or

v. If the applicant is any other business form, any authorized officer;

2. A Release Authorization directing all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division, which shall be dated, notarized and signed by the following:

i. If the applicant is a corporation, the president or any other authorized officer;

ii. If the applicant is a partnership, a partner;

iii. If the applicant is a limited partnership, a general partner;

iv. If the applicant is a sole proprietorship, the sole proprietor; or

v. If the applicant is any other business form, any authorized officer; and

3. An acknowledgment of receipt of notice regarding confidentiality, consent to search and nonrefundability of filing fees, which shall be dated, notarized and signed in accordance with (b)2i through v above.

19:41-5.8 Business Entity Disclosure Form—Holding Company

(a) A Business Entity Disclosure Form—Holding Company (BED-HC) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Any official or trade name used by the applicant;

2. The enterprise as to which the applicant has been identified as a holding company and, if different, the applicant for casino service industry licensure for which the BED-HC is being submitted;

3. The name and telephone number of a person to be contacted in reference to the application;

4. Current or former business addresses of the applicant enterprise;

5. The business form of the enterprise, and a copy of the certificate of incorporation, charter, by-laws, partnership agreement, trust agreement or other basic documentation of the enterprise;

6. The name and location of any government agency in this State or any other jurisdiction that regulates the applicant, and the nature and extent of regulation;

7. Whether the applicant has had any license or certificate denied, suspended or revoked by any government agency in this State or any other jurisdiction, the nature of such license or certificate, the agency and its location, the date of such action, the reasons therefor and the facts related thereto;

8. The following financial information:

i. Two copies of the applicant's most recent financial statement and Federal and state tax returns;

ii. Information regarding any judgments or petitions for bankruptcy or insolvency and any relief sought under any provision of the Federal Bankruptcy Act or any state insolvency law; and any receiver, fiscal agent, trustee or similar officer appointed for the applicant's property or business;

9. Civil, criminal and investigatory proceedings in any jurisdiction, as follows:

i. Information regarding any indictment, charge or conviction for any criminal or disorderly persons offense;

ii. Any criminal proceeding in which the applicant has been a party or has been named as an unindicted co-conspirator; and

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iii. Any judgment, consent decree or consent order entered against the applicant pertaining to a violation or alleged violation of the Federal antitrust, trade regulation or securities laws or similar laws of any jurisdiction; and

10. The name, home address, date of birth, title or position and percent of ownership, where applicable, of each of the following persons or entities:

i. Any officer, director, trustee *[or]* ***,*** partner ***or sole proprietor***;

ii. Each beneficial owner, whether an enterprise or natural person, of more than five percent of the outstanding voting securities of the applicant;

(b) In addition to the information in (a) above, a completed BED-HC may include the following:

1. A certification of truth, which shall be dated, notarized and signed by the following:

i. If the applicant is a corporation, the president or any other authorized officer;

ii. If the applicant is a partnership, each partner;

iii. If the applicant is a limited partnership, each general partner;

iv. If the applicant is a sole proprietorship, the sole proprietor; or

v. If the applicant is any other business form, any authorized officer;

2. A Release Authorization directing all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division, which shall be dated, notarized and signed by the following:

i. If the applicant is a corporation, the president or any other authorized officer;

ii. If the applicant is a partnership, a partner;

iii. If the applicant is a limited partnership, a general partner;

iv. If the applicant is a sole proprietorship, the sole proprietor; or

v. If the applicant is any other business form, any authorized officer; and

3. An acknowledgment of receipt of notice regarding confidentiality, consent to search and nonrefundability of filing fees, which shall be dated, notarized and signed in accordance with (b)2i through v above.

19:41-5.9 Qualifier Disclosure Form

(a) A Qualifier Disclosure Form (QDF) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Name, including any aliases or nicknames;
2. Telephone number, address and residence history;
3. Position held with the casino service industry license applicant or holding company;
4. Date and place of birth;
5. Physical characteristics;
6. Employment history;
7. Information regarding any license, permit, approval, registration or other authorization to participate in a lawful gambling operation held by or applied for by the applicant in this State or any other jurisdiction; and
8. Arrests, charges or offenses committed by the applicant.

(b) In addition to the information in (a) above, a completed QDF may include the following:

1. An original photograph of the applicant taken within the previous 12 months;
2. A signed, dated and notarized certification of truth; and
3. A signed, dated and notarized Release Authorization which shall direct all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division.

19:41-5.10 Qualifier Renewal Disclosure Form

(a) A Qualifier Renewal Disclosure Form (QRDF) shall be in a format prescribed by the Commission and may require the applicant to provide the following information:

1. Name, including any aliases or nicknames;
2. Telephone number, address and residence history;
3. Position held with the casino service industry license applicant;
4. Date and place of birth;
5. Physical characteristics; and
6. Arrests, charges or offenses committed by the applicant since the date on which the applicant last filed a Qualifier Disclosure Form (QDF) or QRDF.

(b) In addition to the information in (a) above, a completed QRDF may include the following:

1. A signed, dated and notarized certification of truth; and
2. A signed, dated and notarized Release Authorization which shall direct all courts, probation departments, selective service boards, employers, educational institutions, financial and other institutions and all governmental agencies to release any and all information pertaining to the applicant as requested by the Commission or the Division.

19:41-7.14 (Reserved)

19:44-3.2 Gaming school certificate of operation standards

(a)-(b) (No change.)

NOTE: A Statement of Gaming School Proposal was adopted by the Casino Control Commission as part of R.1977 d.475, effective December 15, 1977. This statement is not reproduced herein, but can be obtained from:

Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, New Jersey 08401
or
Office of Administrative Law
Administrative Filings
CN 049
Trenton, New Jersey 08625

(a)

CASINO CONTROL COMMISSION

Gaming Schools

Readoption with Amendments: N.J.A.C. 19:44

Proposed: June 21, 1993 at 25 N.J.R. 2660(a).

Adopted: August 4, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: August 9, 1993 as R.1993 d.430, **without change**.

Authority: N.J.S.A. 5:12-63c, 69a, 70a-b, 90b and 92.

Effective Date: August 9, 1993, Readoption;
September 7, 1993, Amendments.

Expiration Date: December 15, 1996.

Summary of Public Comments and Agency Responses:

Comments were received from the Boardwalk & the Marina Casino Dealers School of Atlantic City, Inc. ("Casino Dealers School").

COMMENT: Casino Dealers School comments that, other than N.J.A.C. 19:44-17.4, Classified columns, the rules "are unclear as to where other types of advertisements can be placed if the school does not use classified columns," and "what other types of advertisements are permissible."

RESPONSE: Subchapter 17 sets forth general standards for various types of advertising by gaming schools. Although these comments are beyond the scope of the proposal to readopt, the Commission would note that it plans to review a number of topics in Chapter 44 in the near future, including the issue of advertising by gaming schools, and will consider the suggestions of the commenter at that time.

COMMENT: Casino Dealers School stated that it does not object to the readoption of Chapter 44. However, it suggested several topics for

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future amendments to the chapter. One such request was that the Commission adopt uniform grading standards and a maximum time frame for a student's completion of a required course. It also states that the methodology in which a school may conduct its "teacher contact hours" and "laboratory and practice hours" is unclear, and suggests specific methodology standars.

RESPONSE: Such suggestions, citing areas for future rulemaking, are beyond the limited scope of this proposal to readopt, to which the commenter has no objection. The commenter's suggestions will be considered in conjunction with future review and revision of Chapter 44. It should nonetheless be noted that the Commission has quantitative minimum standards, set forth at N.J.A.C. 19:44-8.3, for the training of casino dealers. In addition, each gaming school submits its program of instruction for Commission review and approval of, among other things, method and frequency of evaluation and the nature of skill and knowledge that students are expected to have have upon graduation. N.J.A.C. 19:44-8.1. As to teacher contact hours and laboratory or practice hours, N.J.A.C. 19:44-8.2 distinguishes between these for purposes of describing the requisite course or program outline. The rule does not prescribe specific methodology, but rather, requires prior Commission review and approval of such course or program of instruction.

COMMENT: Casino Dealers School seeks amendment of the definition of "administrative employee" in N.J.A.C. 19:41-1.1, suggesting additional descriptive standards and examples other than the three positions listed in the definition, and suggests that the term "clerical personnel or employee," as used in N.J.A.C. 19:44-5.1, should be expressly defined in the rules. Similarly, it suggests that the rules add a defined term "training and instruction hour" for purposes of N.J.A.C. 19:44-8.3, noting that the terms "hour," "clock hour," and "instructional hour" may be terms of art in the academic field.

RESPONSE: N.J.A.C. 19:41-1.1 defines an "administrative employee" as "any person employed by a gaming school in a nonteaching capacity including, but not limited to, the business manager, director of admissions, and the director of placement." The phrase "including, but not limited to" indicates that the three positions noted are not intended to provide an exclusive listing of "administrative employee" positions. The term "clerical employees" is given its common meaning. Likewise, N.J.A.C. 19:44-8.3 simply refers to "hours of training and instruction," without any specialized definition for purposes of these rules. However, as indicated above, the Commission intends in the near future to address various issues in Chapter 44 as part of its ongoing regulatory review process, and the comments submitted herein will be reviewed by the Commission in conjunction with that rulemaking.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 19:44.

Full text of the adopted amendments follows:

19:44-5.1 Establishment of qualifications

(a) No natural person shall be employed by a licensed gaming school as an instructor, administrative employee or a sales representative unless he shall first have established his qualifications in accordance with the casino employee standards set forth in sections 92b, 86 and 90 of the act and the regulations of the commission and unless a gaming school employee license authorizing the person to hold the particular position of employment shall first have been issued to him, provided, however, that notwithstanding the provisions of this section, the licensure of clerical personnel shall not be required.

(b) (No change.)

19:44-17.4 Classified columns

Schools using classified columns of newspapers or other publications to procure students must use only such columns as are headed by "Education", "Schools", or "Instruction". Classification such as "Business Opportunities", "Employment", "Help Wanted", may be used only to procure employees or agents for the school.

(a)

CASINO CONTROL COMMISSION

Nature and Exchange of Gaming Chips, Slot Tokens and Plaques

Adopted Amendment: N.J.A.C. 19:46-1.5

Proposed: June 7, 1993 at 25 N.J.R. 2233(a).

Adopted: August 4, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: August 9, 1993 as R.1993 d.431, **without change**.

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(i) and 100(d).

Effective Date: September 7, 1993.

Expiration Date: April 15, 1998.

Summary of Public Comment and Agency Response:

COMMENT: The Division of Gaming Enforcement supports the proposal, and the Sands Hotel and Casino indicated that it does not object to the adoption of the proposal.

RESPONSE: Accepted.

COMMENT: Trump's Castle Casino Resort (Castle) opposes the proposal. Castle claims it would result in major inconvenience for its patrons, who would have to redeem their chips at the cage and then purchase replacement chips whenever the active chips were changed. Castle also contends that because its dealers handle more chips than cashiers, they are now more adept at detecting counterfeit chips than cage personnel.

RESPONSE: Rejected. The removal and replacement of a casino's gaming chips is a relatively rare occurrence. If patrons are permitted to exchange their inactive chips at the gaming tables for the new replacement chips, the primary purpose of replacing the chips, which is the detection of counterfeit chips, would be partially defeated.

Although it is true that dealers handle a great deal of gaming chips, it does not necessarily follow that dealers are any more or less adept than other casino personnel in detecting counterfeit chips. In fact, although dealers should be concerned with protecting the integrity of their games, the detection of counterfeit chips is not one of a dealer's primary functions. The Commission believes that cage personnel are no less qualified to detect counterfeits, and should be in a better position to do so, since verification and redemption of gaming chips is a primary function of the casino cage.

It should also be noted that this amendment simply codifies existing practice; in the several years that this procedure has been utilized, the difficulties envisioned by Castle have not occurred.

Full text of the adoption follows:

19:46-1.5 Nature and exchange of gaming chips, slot tokens and plaques

(a) All wagering on authorized games in a casino or casino simulcasting facility shall be conducted with gaming chips or plaques; provided however, that slot tokens or coins shall be permitted for use in slot machines or simulcast wagering. Gaming chips previously issued by a casino licensee which are not in active use by that casino licensee shall not be used for wagering at authorized table games or casino simulcasting, and shall not be accepted nor exchanged for any purpose at a gaming table or a casino simulcast counter. Such chips shall only be redeemed at the cashiers' cage pursuant to (f) below.

(b)-(k) (No change.)

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(a)

CASINO CONTROL COMMISSION

Gaming Equipment

Issuance and Use of Slot Tokens for Gaming; Slot Token Specifications

Adopted Amendments: N.J.A.C. 19:46-1.33

Proposed: May 17, 1993 at 25 N.J.R. 1961(a).
Adopted: August 4, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: August 9, 1993 as R.1993 d.432, **without change**.
Authority: N.J.S.A. 5:12-63(c), 69(a), 70(i) and 100(d).
Effective Date: September 7, 1993.
Expiration Date: April 15, 1998.

Summary of Public Comment and Agency Response:

COMMENT: The Sands Hotel and Casino and the Division of Gaming Enforcement indicated they do not object to the proposal.

RESPONSE: Accepted.

COMMENT: The Olde Philadelphia Mint, Inc. (OPM) supports the proposal, but suggests that the Commission also incorporate by reference in N.J.A.C. 19:46-1.33(a)11, a specific anti-counterfeiting feature developed by OPM.

RESPONSE: Rejected. The proposal intentionally omits mention of any specific security measures, the details of which would probably be considered confidential information under N.J.S.A. 5:12-74(d). The Commission also decided not to specify any particular proprietary anti-counterfeiting measure in N.J.A.C. 19:46-1.33(a)11, in order to avoid any appearance that it was endorsing or recommending one measure over another.

COMMENT: JOM, Inc. d/b/a Chipco International Ltd. (Chipco), noted that it is now developing a slot token which will consist of a metal core covered with a polymer resin. It is concerned that such a token may not be permitted by proposed N.J.A.C. 19:46-1.33(a)10, which requires slot tokens to be "manufactured from a metal or metals approved by the Commission." While Chipco notes that the proposed regulation does not expressly prohibit such a slot token, it suggests that the proposal should be amended to expressly permit the proposed token, so long as all of the materials in the token are approved by the Commission.

RESPONSE: Rejected. This proposal simply codifies existing slot token specifications, which presently require "metal tokens" under N.J.A.C. 19:46-1.33(a). Slot tokens constructed with other materials, or combinations of metal and other materials, raise issues of compatibility, durability, and security, none of which have yet been addressed by the Commission; indeed, the proposed Chipco slot token is still being developed, and has not yet been submitted to the Division of Gaming Enforcement for testing, or to the Commission for approval.

Given these circumstances, the Commission believes the Chipco comment is beyond the scope of this proposal, and that it is premature to address any issues raised by the proposed Chipco composite tokens at this time.

COMMENT: Chipco also notes that the language of N.J.A.C. 19:46-1.33(a)10 may present difficulties with respect to some slot tokens already in use in Atlantic City casinos. The tokens in question are manufactured with a clear epoxy coating, which purportedly prevents premature wear of the token and maintains its lustre. Chipco suggests that the text of the amendment, on its face, may prohibit the coating process.

RESPONSE: Rejected. Unlike the proposed Chipco process, which appears to involve a metal core encased in a plastic shell, the microscopic protective coating in question is not an intrinsic feature in the design and construction of the token, and does not raise the same operational issues as the proposed Chipco token.

COMMENT: Chipco also objects to N.J.A.C. 19:46-1.33(a)3 and (a)4, which require statements on the face of a slot token that it is "not legal tender" and is acceptable only at the casino which issued it. Chipco contends that such language is unnecessary, since it is not required by Federal law, and because experience has demonstrated that casino patrons and merchants both understand that such tokens only have value within the casino issuing them, and are not used as money outside of the casino. Chipco claims that these requirements limit the design flexibility of the surface graphics, and should be eliminated.

RESPONSE: Rejected. The language in question is not new, and the Commission believes it important enough to continue its required placement upon all slot tokens, even though it may impinge upon slot token graphic design to a minor extent. N.J.A.C. 19:46-1.5(a) and (e) require that slot tokens be used only in slot machines or for simulcast wagering, and that such tokens are considered solely as evidence of a debt owed to their custodian by the casino licensee. Despite Chipco's assertions, it is doubtful that all of the casino patrons who purchase slot tokens are aware of these limitations, so that these notices should be retained.

Full text of the adoption follows:

19:46-1.33 Issuance and use of tokens for gaming; slot token specifications

(a) A casino licensee may, with Commission approval, issue metal tokens designed for gaming use in its slot machines and in simulcast wagering, provided that each such slot token:

1. Clearly identifies the name or trade name and location of the issuing casino;
2. Clearly states its face value;
3. Contains a statement that the token is acceptable only at the casino issuing it;
4. Contains the statement "Not Legal Tender";
5. Is not deceptively similar to any current or past coin of the United States or a foreign country;
6. Is of a size or shape or has other characteristics which physically prevents its use in lawful vending machines or other machines designed to be operated by coins of the United States, except slot machines;
7. Is not manufactured from:

i. A three-layered material consisting of a pure copper core clad on both sides with a copper-nickel alloy;

ii. A copper based alloy, unless the total zinc, nickel, aluminum, magnesium and other alloying metal exceeds 25 percent of the token's weight; or

iii. A ferromagnetic material;

8. Shall not have a diameter which is between:

0.680 inch and 0.860 inch
0.890 inch and 0.980 inch
1.018 inches and 1.068 inches
1.180 inches and 1.230 inches
1.475 inches and 1.525 inches

9. Shall not weigh less than two grams and shall not be less than 0.060 inch thick;
10. Is manufactured from a metal or combination of metals approved by the Commission;
11. Incorporates such anti-counterfeiting features and other security measures as the Commission may require; and
12. Contains a statement that it is not redeemable for cash, if the slot token is issued pursuant to section (c)2 below.

(b) In addition to the above requirements, the following denominations of slot tokens must also meet the following specifications, with manufacturing tolerances approved by the Commission:

Denomination	Diameter
$ 1.00	1.469 inches
$ 2.00	1.340 inches
$ 5.00	1.750 inches
$ 10.00	1.700 inches
$ 25.00	1.875 inches or 1.950 inches
$100.00	1.600 inches
$500.00	1.550 inches

(c) No casino licensee shall issue or cause to be utilized in its casino any tokens for gaming use in slot machines unless and until such tokens are approved by the Casino Control Commission. In requesting approval of any slot tokens, a casino licensee shall first submit to the Commission a detailed schematic of its proposed token which shall show the front, back and edge of the token, its diameter, thickness and any logo, design and wording thereon, all of which shall be depicted on the schematic as they will appear, both as to size and location, on the actual slot token. Once the design schematic is approved by the Casino Control Commission or its designee, no

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slot token shall be issued or utilized until and unless a sample of the token is also submitted to and approved by the Commission.

(d) A slot token shall be capable of insertion into and activating the play of a designated slot machine operated by the casino licensee which issued the slot token.

1. A slot token that is redeemable by the patron pursuant to N.J.A.C. 19:46-1.5(f)(1) shall:

i. Be issued upon a patron's request, or be issued in accordance with a complimentary distribution program authorized pursuant to N.J.A.C. 19:45-1.46;

ii. Be available as a payout from the slot machine payout reserve container (hopper); and

iii. Be available for use in simulcast wagering.

2. A slot token that is exchangeable only for a coupon pursuant to N.J.A.C. 19:46-1.5(f)2 shall:

i. Be issued only in accordance with a complimentary distribution program authorized pursuant to N.J.A.C. 19:45-1.46;

ii. Not be available as a payout from the slot machine hopper; and

iii. Be retained in a separate slot drop bucket or slot drop box, pursuant to N.J.A.C. 19:46-1.25(h); and

iv. Not be available for use in simulcast wagering.

HEALTH

(a)

OFFICE OF THE COMMISSIONER

Catastrophic Illness in Children Relief Fund Program

Adopted Amendments: N.J.A.C. 8:18

Proposed: June 7, 1993 at 25 N.J.R. 2169(a).

Adopted: August 11, 1993, Catastrophic Illness in Children Relief Fund Commission, Bruce Siegel, M.D., M.P.H., Chairman and Commissioner of Health, Department of Health.

Filed: August 12, 1993 as R.1993 d.438, **without change.**

Authority: N.J.S.A. 26:2-148 et seq., specifically 26:2-154i.

Effective Date: September 7, 1993.

Expiration Date: November 6, 1994.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

8:18-1.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

...

"Catastrophic Illness" means any illness or condition for which the incurred medical expenses not covered by any other State or Federal program or any other insurance contract exceed 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000.

"Child" means a person under 19 years of age.

"Commission" means to the 11 member Catastrophic Illness in Children Relief Fund Commission created by the Act and appointed by the Governor to administer the Fund. The Commission, chaired by the Commissioner of Health, is "in but not of" the Department of Health.

...

"Eligibility standard" means that dollar amount equal to 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000.

...

"Threshold" means the point at which a child's out-of-pocket medical expenses exceed 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000. After the child's medical expenses reach this threshold, a child has passed the initial screen for eligibility for assistance from the Fund.

8:18-1.3 General requirements

(a) Pursuant to the Act, the Fund will provide assistance to families having a child with a catastrophic illness. A child shall have passed the initial screen for eligibility for the Fund's assistance when a child's incurred medical expenses (not covered by private insurance or other public programs) for a prior consecutive 12 month period exceed the amount represented by 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000.

1. Fifteen percent shall be the screen used for families whose income is $100,000 or less.

2. Fifteen percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000 shall be the screen used for families whose income is more than $100,000.

(b) (No change.)

(c) To be eligible for assistance, a child must be a resident of the State of New Jersey. Resident means a person legally domiciled in New Jersey for a period of three months immediately preceeding the initial date of application for assistance to the Fund.

1.-4. (No change.)

8:18-1.6 Eligibility standard

Incurred, out-of-pocket medical expenses up to the 15 percent of the first $100,000 of annual income for a family plus 20 percent of the excess income over $100,000 threshold shall be required for eligibility consideration. Those expenses above the family responsibility and up to the cap shall be considered for reimbursement after the eligibility standard is determined and met (see examples in Appendix I).

8:18-1.11 State Office responsibilities

(a) The State Office shall:

1. Screen applications to determine whether a child's medical expenses exceed 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000;

2.-7. (No change.)

8:18-1.12 Commission responsibilities

(a) The Catastrophic Illness in Children Relief Fund Commission shall be responsible to:

1. Develop policies and procedures for operation of the Fund;

2. Meet to review and make decisions on applications of families for financial assistance in regularly scheduled cycles; and

3. Negotiate or settle the recovery of funds disbursed in accordance wih the provisions of this chapter.

8:18-1.14 Eligible health services

(a) Categories of incurred health expenses which are medically-authorized in the care of a child with an illness or condition eligible for consideration in assessing whether a family has reached its eligibility threshold of 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000 include, but are not limited to, the following:

1. (No change.)

2. Specialized pediatric ambulatory care, including physician-authorized rehabilitative therapies (for example, speech, occupational, and physical), physician-authorized care for treatment of addiction disorders and mental health care, dental care, eye care, chiropractic care;

3.-11. (No change.)

Recodify existing 14.-15. as 12.-13. (No change.)

14. Experimental medical treatment/experimental drugs which are recognized by Federal or State agencies and provided by licensed health care providers. Applications involving experimental treatment may require additional review.

(b) Categories of incurred health-related expenses are eligible for consideration in assessing whether a family has reached its eligibility threshold of 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000 include:

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1. Family transportation and travel-related expenses including, but not limited to, mileage allowance, tolls, parking receipts, temporary shelter costs and telephone calls related to medical condition.

(c) Fifty percent of a health insurance premium including supplemental and dependent coverage that is paid by a family when accompanied by any other eligible expenses in (a) or (b) above.

8:18-1.15 Ineligible health services

(a) Categories of health and health-related expenses which are not eligible for consideration in assessing whether a family has reached its eligibility threshold of 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000 shall include, but are not limited to, the following:

1. (No change.)

2. Elective cosmetic surgery.

8:18-1.16 Administration of payments

(a) The State Office shall oversee processing of payments from the Fund. Though in general payments shall be made directly to providers and vendors, consideration shall be given to making payments directly to families.

(b)-(c) (No change.)

8:18-1.18 Special cases

(a) Special cases shall be referred to the Commission for its review and consideration. Special cases shall include, but are not limited to, the following:

1. In special cases in which a family has more than one child, with a catastrophic illness (as defined by expenses in excess of the 15 percent of the first $100,000 of annual income of a family plus 20 percent of the excess income over $100,000 threshold for each child), consideration shall be given to waiving the family responsibility as outlined in N.J.A.C. 8:18-1.2 for the other child/children given that the family would have already met the family responsibility for the first child.

2.-3. (No change.)

8:18-1.20 Recovery of Commission expenses

(a) If a family receives assistance from the Fund for a child, in accordance with this chapter, and subsequently recovers damages or a financial award for the child's medical expenses, pursuant to a settlement or judgment in a legal action, the family shall reimburse the Fund for either:

1. The amount of assistance received from the Fund; or

2. The portion of assistance received for the injury, illness or condition covered by the damage or judgment, less the family's expenses of recovery.

(b) The Commission may negotiate or settle the recovery of such claims, for cause presented by the family to the Commission.

APPENDIX I

Examples of Catastrophic Illness in Children Relief Fund Program

The examples below illustrate the extent which the Fund would assist three families with different income levels.

FAMILY #1 (with income of $30,000)	
Family Income:	$30,000
Eligibility Standard (15% of income):	4,500
Amount of Eligible Medical Expenses Not Covered by Insurance:	15,000
Family Responsibility (10% of Family Income):	3,000
Amount of Fund's Financial Assistance to Family:	12,000
Amount for which Family remains responsible:	3,000

FAMILY #2 (with income of $80,000)	
Family Income:	$80,000
Eligibility Standard (15% of income):	12,000
Amount of Eligible Medical Expenses Not Covered by Insurance:	15,000
Family Responsibility (10% of Family Income):	8,000
Amount of Fund's Financial Assistance to Family:	7,000
Amount for which Family remains responsible:	8,000

FAMILY #3 (with income of $120,000)	
Family Income:	$120,000
Eligibility Standard:	$19,000
15% of the first $100,000, or 15,000	
20% of the excess over $100,000, or 4,000	
Amount of Eligible Medical Expenses Not Covered by Insurance:	$30,000
Family Responsibility (10% of Family Income):	$12,000
Amount of Fund's Financial Assistance to Family:	$18,000
Amount for which Family remains responsible:	$12,000

†Assuming: an annual $100,000 cap; adequate monies available in fund obviating need for additional restrictions and cost-sharing; all expenses are reasonable and customary; and none of the cases are in the "special" category.

(a)

DIVISION OF HEALTH CARE PLANNING, FINANCING AND INFORMATION SERVICES

Certificate of Need

Application and Review Process

Adopted Amendments: N.J.A.C. 8:33

Adopted Repeals: N.J.A.C. 8:33-6 and 8:33, Exhibits 1, 2, 3A, 3B

Adopted Recodification with Amendments: N.J.A.C. 8:33-5, Appendix, Exhibits 1, 2 and 3 as N.J.A.C. 8:33 Appendix Exhibits 1, 2, 3

Proposed: June 7, 1993 at 25 N.J.R. 2171(a).

Adopted: August 13, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of Health Care Administration Board).

Filed: August 16, 1993 as R.1993 d.442, **with substantive and technical changes** not requiring additional public notice (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq., as amended.

Effective Date: September 7, 1993.

Expiration Date: July 27, 1995.

Summary of Public Comments and Agency Responses:

The proposal appeared in the New Jersey Register for Monday, June 7, 1993 at 25 N.J.R. 2171(a). Public comment was received on the proposal through July 7, 1993. Written comments were received from: Jeff Brand, executive director, Planned Parenthood of Greater Northern New Jersey, Inc.; Gail R. Callandrillo, director of planning, Holy Name Hospital; Maurice P. Coffee, Jr., assistant to the president and vice president for planning, West Jersey Health System; James E. Cunningham, president, New Jersey Association of Health Care Facilities; Ralph A. Dean, executive vice president and interim chief executive officer, New Jersey Hospital Association; John D. Fanburg and Todd C. Brower, attorneys, Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone, P.C.; Leonard Fishman, general counsel, New Jersey Association of Non-Profit Homes for the Aging; Phyllis Kinsler, executive director, Planned Parenthood of Monmouth County, Inc.; Anita Leone, executive director, Family Planning Association of New Jersey; Andrea W. Miller, president, Healthcare Planning and Marketing Society of New Jersey; Vera Raskin, senior manager, strategic services, Monmouth Medical Center; Christine Reynolds, RN, program analyst, New Jersey Family Planning League, Inc.; Theodosia A. Tamborlane, Esq., Theodosia A. Tamborlane, P.C.; and Neil E. Weisfeld, director of eduction research and regulatory affairs, Medical Society of New Jersey.

1. COMMENT: N.J.A.C. 8:33-1.3 Definitions and Appendix, Exhibit 2. A number of commenters suggeted that abortion services be removed from the listing of health care services requiring certificate of need at Exhibit 2 and that the definition of "community-based primary care center" at N.J.A.C. 8:33-1.3 include reference to "reproductive health services." Among those urging the elimination of the certificate of need requirement for abortion services are Mr. Brand of Planned Parenthood of Greater Northern New Jersey, Inc.; Mr. Coffee of West Jersey Hospital System; Mr. Dean of the New Jersey Hospital Association; Ms.

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Leone of the Family Planning Association of New Jersey; Ms. Kinsler of Planned Parenthood of Monmouth County, Inc.; and Ms. Reynolds of the New Jersey Family Planning League, Inc. A number of these commenters claimed that in consideration of goals reflected in the State planning documents, reproductive health services including family planning services should be routinely available and accessible and that outpatient reproductive health services are fundamentally community-based primary care services. As such, they argue, they should be exempted from certificate of need requirements consistent with the exemption given to community-based primary care centers pursuant to section 19 of P.L.1971, c.136, as amended.

RESPONSE: The Department agrees with the position taken by these commenters that outpatient reproductive health services including abortion services represent primary care services that are and should be delivered at the community level and, as such, the elimination of certificate of need requirements for them is consistent with the statutory mandate exempting community based primary care centers from certificate of need requirements.

2. COMMENT: N.J.A.C. 8:33-1.3 Definitions. Commenters stated that the definition of "subject to a health planning regulation" specified at N.J.A.C. 8:33-1.3 oversteps legislative authorization and intent by being overly broad and including a number of health care services which, according to the comments, are neither the subject of a health planning regulation nor are they listed in the definition of a health care service or health care facility in the enabling legislation. Examples given were, special child health clinics providing tertiary services, abortion services, comprehensive personal care homes, assisted living residecies, and hyperbaric chambers. They argue that until discrete planning regulations are adopted for these services, they are not regulated. It was suggested that listing certain services as included in the Certificate of Need Program without regulations concerning those services currently in effect will result in an "unfounded and arbitrary" review of applications.

RESPONSE: The term "subject to a health planning regulation" is intended to define the range of services that are subject to both certificate of need and licensure requirements. Section 7 of the Health Care Facilities Planning Act (N.J.S.A. 26:2H-7, as amended) mandates that no health care facility shall be constructed or expanded and no new health care service shall be instituted after the effective date of the law except upon application for and receipt of a certificate of need. It goes on to state in this same section that the initiation of any health care service as provided in section 2 (N.J.S.A. 26:2H-2, as amended) requires a certificate of need. Section 2 defines a "health care service" as the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing etc. Accordingly, each of the services identified in the rule is properly the subject of the certificate of need requirement. During the course of the recent moratorium on certificate of need, certain service specific regulations were permitted to lapse. This did not remove these services from the purview of the statute. Furthermore, listing these services as regulated will not lead to an arbitrary review of the applications. The Department will assuredly promulgate effective regulations to govern the review of each regulated service before the Commissioner issues a call for applications for such service.

3. COMMENT: N.J.A.C. 8:33-2.3, Waivers to certificate of need requirements for physicians, and N.J.A.C. 8:33-2.4, Waivers to certificate of need requirements for health maintenance organizations. It was noted that the provisions of N.J.A.C. 8:33-2.3 and 2.4 bar a physician or health maintenance organization from filing a certificate of need application and a waiver application simultaneously, which prohibition is not contained in legislation. The complaint is that as each application requires a $5,000 filing fee, the practical effect is to provide the Department with additional funds and to delay the applicant from being able to provide the intended health care service.

RESPONSE: The provision of the rule addressed in this comment was formally adopted by the HCAB on August 13, 1992 and is not the subject of the proposed amendments. However, it is noted that no fee is charged by the Department for the processing of waiver petitions and the petitioner need not await the issuance of a CN call to file one.

4. COMMENT: N.J.A.C. 8:33-3.1 and Appendix, Exhibit 2. In reference to the listing of orthopedic beds as a distinct health care service at Exhibit 2, comments were received that since orthopedics constitute a part of the medical/surgical bed category, it should not be separately listed. Another commenter questioned why hospice programs have been removed from the list.

RESPONSE: The reference to orthopedic beds has been deleted from Exhibit 2 of the appendix, since they indeed are part of the medical/surgical bed category. Hospice services in New Jersey are principally offered in a patient's home by a licensed home health agency. Where they are offered in a residential setting, a potential provider would have to apply for a certificate of need to establish a residential facility and would be required to describe its proposed hospice program in that application. If a potential provider were proposing to initiate the service by establishing a new home health agency that provider would be subject to certificate of need requirements for the establishment of a home health agency. Thus, to require an additional certificate of need for hospice care would be duplicative, costly, and inefficient and is contrary to the Department's efforts to streamline the certificate of need process.

5. COMMENT: N.J.A.C. 8:33-3.2. A commenter noted that N.J.A.C. 8:33-3.2(d) is burdensome and that discontinuance of a component service should not require a certificate of need. The need for rapid response to managed care agreements calls for the unhindered ability to transfer component services between facilities or for their total elimination. Commenters suggested that a specific timeframe be included for the Department to review such applications or that a filing fee not be required for certificate of need applications for discontinuance of services.

RESPONSE: A licensed health care facility should not be able to discontinue or relocate a component service without at least the Department's consideration of the impact that the discontinuance may have on the public's access to health care. The Department seeks to streamline the certificate of need process and avoid unnecessary regulatory barriers. It is for that reason that it has proposed to eliminate the certificate of need requirement for the discontinuance of a component service of a health care facility where there is no empirical basis to conclude that the discontinuance will offend issues of quality and access. Where the Department believes that there are access implications resulting from the proposed elimination or relocation of the service, a careful and accountable examination of the impact of the proposal will occur by requiring the provider to submit a certificate of need application. This is consistent with the Department's statutory responsibilities and does not impose an unnecessary burden on providers. The Department will make every effort to provide timely notice of whether or not a certificate of need is required and by proposing that the application be processed via expedited review procedures has committed to a timely resolution of the matter.

6. COMMENT: N.J.A.C. 8:33-3.3, Transfer of a health care service/facility. Comments were received suggesting that the Health Care Facilities Planning Act, as amended, has exempted all transfers of ownership of both facilities and services from certificate of need review except for the transfer of an acute care hospital or a long term care facility with a history of licensing deficiencies or failure to comply with Medicare or Medicaid requirements. An objection was raised to the requirement for a certificate of need review of an acute care hospital when a hospital acquires new provider numbers as a result of a transfer. Comments concerning the application of this rule to services whose establishment were grandfathered under the Health Care Cost Reduction Act were received. Specifically, it was questioned whether the requirement to obtain a CN for the transfer of a service should apply to services whose initiation was grandfathered. With regard to N.J.A.C. 8:33-3.3(m)1, it was also suggested that a physician who has a grandfathered project or has received a waiver should be permitted to transfer the service by way of an expedited review since a certificate of need was not required to operate the service in the first instance. Otherwise it is argued a retiring physician would have to wait for an MRI batch before being able to sell the practice. If a batch is not called for, his practice becomes worthless. If a batch is called for, the process is time consuming and costly.

RESPONSE: Section 19 of the Health Care Reform Act (P.L.1992, c.160) amended the Health Care Facilities Planning Act by eliminating the certificate of need requirement for the transfer of an ownership interest except in the case of a transfer of ownership interest in an acute care hospital or in the case of a long-term care facility in which the owner does not satisfy the Department of Health's review of the owner's prior operating experience as well as any requirements established by the federal government pursuant to Titles XVIII and XIX of the Social Security Act. The Department's requirement of a certificate of need for

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transfers of ownership interest, as set forth at N.J.A.C. 8:33-3.3, inclusive of the transfer of an entire acute care hospital, independent of its licensing history, and the transfer of an acute care service owned and/or operated by an acute care hospital, is entirely consistent with statutory provisions set forth in the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq. The statute also supports a commitment to the regionalization of costly tertiary services, exemplified in the requirement that any service which is the subject of an adopted health planning regulation requires a certificate of need, independent of who will provide the service. If the Department interpreted the statute to allow the transfer of ownership of any acute care service held by a hospital without a certificate of need, it would essentially destroy the capacity to insure proper regionalization of tertiary services in the State. The practical effect of such an interpretation is that a hospital offering heart surgery in northern New Jersey could transfer the heart surgery program to a hospital in southern New Jersey in exchange for that hospital's radiation therapy program. If this were to occur, the very basis for state health planning would be destroyed and the statute's goals to protect the public's access to care, to provide hospital and related health care services of the highest quality, of demonstrated need, efficiently and in a manner in which they would be properly utilized and offered at a reasonable cost would be undermined.

The term "grandfathering" in this section refers to the provision of P.L.1991, c.187, which eliminates the certificate of need requirement for a physician's acquisition of major moveable equipment pursuant to N.J.S.A. 26:2H-7, as amended, if a contract to purchase that equipment was entered into by the physician prior to July 1, 1991. A certificate of need is required for the transfer of ownership of a grandfathered project involving major moveable equipment. With the passage of P.L.1991, c.187, the scope of certificate of need review was broadened to include the initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department of Health and the purchase by any person of major moveable equipment whose total cost is over $1 million. The grandfathering provision was included in the 1991 legislation in order to hold harmless from financial or other harm a physician who had entered into a contract to acquire major moveable equipment prior to the passage of P.L.1991, c.187. No provision exempted from certificates of need requirements acquisitions made after July 1, 1991 of major moveable equipment or medical equipment which is the subject of a health planning regulation. Therefore, it is entirely consistent with the scope and intent of the legislation to require certificate of need for the initiation of a health care service which is the subject of a health planning regulation, even where the initiation of the service occurs as a result of the transfer of grandfathered equipment to a new provider. This position is further affirmed by the amendments that occurred to the law in 1992 (N.J.S.A. 26:2H-19), which exempted from certificate of need requirements the acquisition by a hospital of a magnetic resonance imager (MRI) that is already in operation in the State by another health care provider or entity. The Legislature was very specific here: it only exempted operating MRIs and only when they were being acquired by hospitals. However, the Department agrees with the arguments in favor of streamlining the certificate of need process as it relates to the transfer of a grandfathered or waivered service and has amended the rule at N.J.A.C. 8:33-3.3(a)5 and 6 accordingly.

7. COMMENT: N.J.A.C. 8:33-3.4(a)1 and 2, concerning reduction in beds. A comment was received that clarification was needed to address the following. At N.J.A.C. 8:33-3.4(a)1ii, the Department correctly noted that the increase or decrease in bed complement of existing residential health care facilities are exempt from certificate of need. However, at N.J.A.C. 8:33-3.4(a)2, the Department stated that any decrease in the number of licensed beds by licensure and/or health planning category requires a certificate of need and shall follow the full review process where the reduction in the licensed beds will result in a capital expenditure greater than the monetary threshold specified in N.J.A.C. 8:33-3.6 or where the bed reduction would violate a condition of certificate of need approval imposed upon a provider, as determined by the Commissioner.

RESPONSE: Changes in bed capacity of existing residential health care facilities are specifically exempted from certificate of need requirements pursuant to the provisions of the Health Care Reform Act, P.L.1992, c.160 (N.J.S.A. 26:2H-19, as amended). The Department's acknowledgement of this exemption is recognized at N.J.A.C. 8:33-6.1(a)5 of this proposal. Moreover, the language of N.J.A.C. 8:33-3.4(a)2 clearly states that "the provisions of this subsection do not apply in the case of an applicant proposing the reduction or elimination of residential health care beds or the closure of a residential health care facility."

8. COMMENT: N.J.A.C. 8:33-3.5, Buildings. Several commenters state that N.J.A.C. 8:33-3.5(a)3 gives the Department too much discretion to decide what is a "satellite location" for a primary care center and notes that the criteria should be defined more clearly. One commenter suggested that there should be no notification requirement to the certificate of need program for a determination since it is unlikely that providers will establish a satellite facility if it is not truly needed and projected to be financially feasible. Another commenter indicated that N.J.A.C. 8:33-3.5(a)5 is vague as it does not set forth time frames and further suggests that since there is no application requirement in the Act for relocation or replacement of an entire facility, there should be no requirement for an application for relocation or replacement of a component service of a facility.

RESPONSE: A satellite location is not subject to the Department's discretion, but is defined at N.J.A.C. 8:33-1.3 wherein it specifically defines "satellite" as a community-based primary care center which is an affiliate of a separately licensed ambulatory care facility. A satellite is located at a site distinct from that of the separately licensed ambulatory care facility, but shares the same governing authority and provides the same principal service as the separately licensed ambulatory care facility. Since a satellite location is defined, the Department agrees to make the recommended change at N.J.A.C. 8:33-3.5(a)3 and has included language to require notification to and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation for satellite locations. At N.J.A.C. 8:33-3.5(a)5, the Department has initiated a change to delete the words "and replacement" since it is out of context. With regard to the comment regarding the relocation of a component service, please refer to response to Comment 5.

9. COMMENT: N.J.A.C. 8:33-3.7, Major moveable equipment. An objection was made to the certificate of need requirement for the replacement of equipment whose purchase was grandfathered. It was suggested that subjecting such to certificate of need requirements would enhance administrative burdens, suppress competition, divert attention of health planners away from more high-cost issues and encourage providers to keep aging equipment in service beyond appropriate replacement times. It was recommended that N.J.A.C. 8:33-3.7(a) be changed to require certificates of need only for new services involving major moveable equipment only. It was also commented that a certificate of need should not be required if the expenditure for major moveable equipment was less than $1 million.

RESPONSE: Valid concerns were raised with regard to the potential of a provider keeping aging equipment beyond appropriate replacement times. Since the proposed rule already permits a hospital to replace major moveable equipment in accordance with the provisions of N.J.A.C. 8:33-6.1(b), the Department now amends N.J.A.C. 8:33-3.7 to permit the replacement of major moveable equipment by other health care providers without certificate of need approval as long as it is a strict replacement of the major moveable equipment, not an upgrade to new equipment and providing the costs of such replacement are at or below the certificate of need threshold, which is currently set at $1 million.

10. COMMENT: N.J.A.C. 8:33-4.1(a) concerning requests for certificate of need applications. Commenters noted that the Department did not fulfill the CN requirement to publish in February an anticipated schedule of calls for certificate of need applications.

RESPONSE: The Department has developed the referenced schedule of calls. It respectfully notes the comments for the record while at the same time recognizing that the specific issue being addressed is not the subject of the proposal amendments.

11. COMMENT: N.J.A.C. 8:33-4.10, Specific criteria for review. Commenters expressed concern about N.J.A.C. 8:33-4.10(e)3 which departs from the requirements relating to licensure track record in the long-term care policy manual (N.J.A.C. 8:33H). Concerns centered on the proposed language which may be interpreted to mean that any deficiency, no matter how minor, would have to be construed as constituting a serious risk to life, safety, or quality of care. In addition it was noted there are cases when a denial of admission or discharge may be inappropriate but not malicious or so egregious as to warrant an automatic denial, for example, when caused by an administrative error. It was recommended that the language in this rule be changed to be consistent with the long-term care policy manual and to avoid unnecessary confusion. Commenters suggested limiting the review of an applicant's record of operation to New Jersey and also suggested that the Depart-

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ment not consider the track record of all health care facilities in which the applicant is an owner, operator or manager. It was commented that large and efficient provider systems will be handicapped in CN review since they are more likely statistically to have some licensing violation than small providers. It was suggested that a certificate of need not be denied for an applicant who has been cited for track record deficiencies as long as the applicant effects a performance bond assuring that the cited condition will be corrected expeditiously and that the condition will not reappear during a 12 month period. It was also suggested that N.J.A.C. 8:33-4.10(e)5 specifically identify the agencies the Department will use as resources in considering evidence regarding an applicant's track record.

RESPONSE: Valid issues have been raised with regard to the amendments and the Department supports many of the proposed changes. The rules are being amended accordingly at N.J.A.C. 8:33-4.10(e)3 and 4. The Department does not agree to limit the review of an applicant's records of operation. The Department strongly believes that it is important to consider the applicant's entire record in the operation of health care facilities. Quality of care in health care facilities should not be compromised in any way. It is incumbent on health care providers (whether operating one health care facility or more than one health care facility) to comply with minimum standards. Health care providers who fail to meet minimum standards at existing health care facilities which result in a continuing violation or pattern of violations of licensing and certification standards, should not be allowed to expand their interest in health care until they can redress the violations at existing facilities. The concept of a performance bond is under consideration by the Department. Therefore, it is not appropriate to include changes to these rules at this time. Rather than cite specific State agencies at N.J.A.C. 8:33-4.10(e)5, the intent of this paragraph is to allow the Department to consider all relevant information to determine the capacity of an applicant to operate a health care facility in a safe and effective manner. Therefore, the identification of specific State agencies may be too limiting in providing adequate information to the Department in making its determination.

12. COMMENT: N.J.A.C. 8:33-6.1, Statement of purpose. It was suggested that at N.J.A.C. 8:33-6.1(a)8, the word "new" should be added before "owner" for clarification.

RESPONSE: The rule has been amended accordingly.

13. COMMENT: N.J.A.C. 8:33-6.1(a)15 and Appendix, Exhibit 2. It was suggested that acute renal dialysis services should be deregulated and not require certificate of need review. Since chronic renal services no longer require certificate of need approval pursuant to N.J.S.A. 26:2H-19, as amended, there is no reason to continue to regulate services that have essentially similar quality concerns. Continuing regulation of this service exposes patients to added risk from inter-hospital transfer, as well as added cost from transport and duplication of tests and services. A clarification of "central service agency" was also requested.

RESPONSE: The Department of Health is not prepared to recommend the deregulation of acute renal dialysis services until it has had further opportunity to study both the legal and medical implications of such a proposal. A definition of "central service agency" has been included at N.J.A.C. 8:33-1.3.

14. COMMENT: N.J.A.C. 8:33-6.2, Process. It was suggested that notification to the certificate of need program creates an unnecessary burden and delay to the creation of community health centers since a definition is already included in the rule.

RESPONSE: It is the responsibility of the Department to ensure that the proposed facility is in fact a community based primary care center as defined in these rules and intended to be exempted from the certificate of need requirements by the Health Care Reform Act of 1992, c.160.

Summary of Agency-Initiated Changes:

At N.J.A.C. 8:33-3.4(a), although there was no change in the text, reference to paragraph (a)3 as "No change." was erroneously excluded from the proposal text.

At N.J.A.C. 8:33-3.5(a)5, the words "and replacement" have been deleted. Replacement is not applicable in this paragraph. Therefore, it is out of context.

At N.J.A.C. 8:33-3.3(a)3, to be consistent with the language at N.J.A.C. 8:33-3.3(b), the text of this subsection should make reference to beds and equipment. The paragraph is revised as follows:

3. *[An acute service]* ***Acute*** care ***beds, services or equipment*** owned and/or operated by an acute care hospital. The corporate unbundling of *[an]* acute care ***beds,*** service***s or equipment*** identified in the Appendix, Exhibit 2 owned and/or operated by an acute care hospital shall require a certificate of need. Corporate unbundling refers to the transfer of ownership of *[an]* acute care ***beds,*** service***s or equipment*** owned or operated by an acute care hospital and the establishment of that service under a new corporation and under a separate license from the acute care hospital's license. Applications for such shall follow the expedited review process set forth at N.J.A.C. 8:33-4.1(b); and

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*):

8:33-1.1 Purpose; scope

(a) The purpose of these rules is to implement the provisions of the Health Care Facilities Planning Act, P.L. 1971, c.136, as amended by P.L. 1978, c.83, the Health Care Cost Reduction Act, P.L. 1991, c.187, and the Health Care Reform Act, P.L. 1992, c.160. These rules may be amended as necessary to best implement the statutory provisions and to reflect changing economic and systemic conditions within the health care system.

(b)-(c) (No change.)

(d) In addition, before filing a certificate of need application, prospective applicants are encouraged to contact the Local Advisory Board (LAB) in the service area(s) in which their proposed health care service(s) or facility is planned to examine the relationship of the proposed project with the LAB's plans, the State Health Plan, and appropriate regulations. If the proposed service area overlaps more than one planning region, the applicant should consult with each of the affected LABS.

8:33-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Adult day health care facilities" means a facility which is licensed by the Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical supervision to meet the needs of functionally impaired adult patients exclusively on an outpatient basis.

"Ambulance service" means the provision of emergency or non-emergency medical care and transportation by certified personnel in a vehicle, which is designed and equipped to provide medical care at the scene and while transporting sick and/or injured persons to or from a medical care facility or provider.

. . .

"Central service facility" means a health care facility, regulated by the Department of Health, providing essential administrative and clerical support service to two or more direct providers of health care services in a region and which may also include some direct provision of health care services.

. . .

"Chronic renal dialysis facilities" means a facility in which dialysis is rendered to a patient with end stage renal disease for whom recovery of renal function is not expected.

. . .

"Community-based primary care center" means a health care facility which provides preventive, diagnostic, treatment, management and reassessment services to individuals with acute or chronic illness exclusively on an outpatient basis. The term is used in reference to facilities providing family practice, general internal medicine, general pediatrics, obstetrics, gynecology, and/or clinical preventive services, including community health centers providing comprehensive primary care ***and/or reproductive health services including abortions***. Comprehensive primary care may include the provision of sick and well care to all age groups, from perinatal and pediatric care to geriatric care. For the purposes of this rule, services identified in the Appendix, Exhibit 2, incorporated herein by reference, are not community-based primary care services and, therefore, are subject to the certificate of need requirement.

. . .

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"Continuing care retirement community" means the provision of lodging and nursing, medical or other health related services at the same or another location to an individual pursuant to an agreement effective for the life of the individual or for a period greater than one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. A fee which is less than the sum of the regular periodic charges for one year of residency is not considered an entrance fee.

...

"Health care service" means the preadmission, outpatient, inpatient, and postdischarge care provided in or by a health care facility, and such other items or service as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance or diagnosis or treatment of human disease, pain, injury, disability, deformity, or physician condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his or her private practice, unless the service is the subject of a health planning regulation, as defined in this section adopted by the Department of Health or involves the acquisition of major moveable equipment as specified herein, and services provided by volunteer first aid, rescue and ambulance squads as defined in the New Jersey Highway Safety Act of 1971, P.L. 1971, c.351.

...

"Invalid coach service" means the provision of non-emergency health care transportation, by certified personnel, for sick, infirm or otherwise disabled persons who are under the care and supervision of a physician and whose medical condition is not of sufficient magnitude or gravity to require transportation by ambulance, but does require transportation from place to place for medical care, and whose use of an alternate form of transportation, such as taxicab, bus, other public conveyance or private vehicle, may create a serious risk to life and health.

"Major moveable equipment" means equipment, including installation and renovation, which is the subject of a health planning regulation or which is proposed by the Commissioner to be the subject of a health planning regulation as defined in this section. For purposes of this chapter, major moveable equipment shall include all equipment which receives pre-marketing approval from the U.S. Food and Drug Administration unless the Health Care Administration Board explicitly excludes a specific piece of equipment or a specific technology from the classification of major moveable equipment. Examples of major moveable equipment are identified in the chapter Appendix, Exhibit 3, incorporated herein by reference.

...

"Nonbed related outpatient psychiatric care" means the following, which, to be considered a health care service, must meet standards as prescribed by the rules governing community mental health services and State aid under the Community Mental Health Services Act (N.J.A.C. 10:37):

1. Outpatient care: A setting that provides treatment and related services to people who are not in an immediate crisis. Such persons need services that are longer term than those provided by Emergency/Screening. Yet, such services are also less structured than daily or semi-daily involvement in a partial care program;

2. Partial care: A setting that provides three or more hours daily of program involvement to maximize a client's independence and community living skills. Partial care programs provide or arrange for a full range of services necessary to meet the comprehensive needs of individual clients; and

3. Emergency screening: The provision of 24-hour service, seven days a week, to people in crisis. Emergency/screening offers immediate crisis-intervention and service procurement to relieve client distress and maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in a needs assessment and in service planning.

...

"Operating revenues" means total operating revenues from the hospital's most recent year audited financial statements, which will be inflated using a global economic factor, as defined in N.J.A.C. 8:31B, which measures the change in the prices of goods and services used by New Jersey hospitals.

...

"Outpatient alcoholism service" means the provision of scheduled, or non-scheduled, non-residential diagnostic and primary alcoholism treatment services.

"Outpatient drug service" means the provision of non-residential drug abuse treatment modalities, including methadone maintenance, drug free outpatient and day care services.

"Pediatric day health care facilities" means a facility which is licensed by the Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical supervision to meet the needs of chronically ill and medically fragile children exclusively on an outpatient basis.

...

"Project" means the compilation, during a single calendar year, of architectural, engineering and/or construction services for renovation provided by individuals or firms which are not employees of the hospital and for which financing is required to fund the project. If the hospital incurs capital expenditures without use of the external services as described above, then each planned renovation of any discrete area or unit of the hospital shall be considered a separate project.

...

"Purchase cost" means the cost of acquisition of a single unit of fixed or major moveable equipment including installation and renovation.

...

"Satellite" means a community-based primary care center which is an affiliate of a separately licensed ambulatory care facility. A satellite is located at a site distinct from that of the separately licensed ambulatory care facility, but shares the same governing authority and provides the same principal service as the separately licensed ambulatory care facility.

...

"Subject of a health planning regulation" means any health care service identified in the Appendix, Exhibit 2.

...

8:33-2.3 Waivers to certificate of need requirements for physicians

(a) A physician who initiates a health care service which is the subject of a health planning regulation, as defined at N.J.A.C. 8:33-1.3, or purchases major moveable equipment whose total cost is over $1,000,000, is subject to the certificate of need requirement. However, a physician may apply to the Commissioner for a waiver of the certificate of need requirement.

(b) The application by a physician for a waiver of the certificate of need requirement will be considered pursuant to the following criteria:

1.-2. (No change.)

3. The health care service or equipment is not otherwise available and accessible to patients pursuant to standards identified in the State Health Plan or in specific health planning regulations guiding the review of the proposed service or equipment. However, where these standards are not identified in either the State Health Plan or the relevant health planning regulations, a physician may satisfy this criteria by documenting to the satisfaction of the Commissioner, that the proposed service or equipment is not otherwise available or accessible for geographic, financial or other reasons to patients at a health care facility which has received certificate of need approval for the health care service or equipment within 30 minutes travel time of the physician's proposed site for the planned service or equipment.

(c)-(e) (No change.)

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8:33-2.4 Waivers to certificate of need requirements for health maintenance organizations

(a) A health maintenance organization which furnishes at least basic comprehensive care health services on a prepaid basis to enrollees either through providers employed by the health maintenance organization or through a medical group or groups which contract directly with the health maintenance organization may apply to the Commissioner for a waiver of certificate of need requirements for:

1. (No change.)

2. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department as defined at N.J.S.A. 8:33-1.3;

3. (No change.)

4. The modernization, renovation or construction of a facility by any person, whose total project cost exceeds $1,000,000, if the facility-type is the subject of a health planning regulation as defined at N.J.A.C. 8:33-1.3.

(b)-(e) (No change.)

8:33-3.1 Initiation of health care service

Establishment of any of the specified standard categories of health care services as referenced in N.J.S.A. 26:2H-1 et seq., as amended and/or as identified in the chapter Appendix, Exhibit 2, incorporated herein by reference, or the modification, replacement or expansion of any health care service or facility, regardless of the amount of capital or operating expenditures requires a certificate of need except as exempted by P.L. 1992, c.160 as stated in this chapter.

8:33-3.2 Termination of service and reduction of bed capacity

(a)-(c) (No change.)

(d) Discontinuance of a component service of a health care facility shall not require a certificate of need where the discontinuance will not result in problems of access to populations historically served and is not a service which is required to be a component of an inpatient health care facility. In these instances, the licensed entity shall notify the Department's Certificate of Need Program in writing 60 days prior to discontinuance of the service. The Department will notify the provider whether the proposed discontinuance requires a certificate of need which shall follow the expedited review process set forth at N.J.A.C. 8:33-4.1(b).

8:33-3.3 Transfer of a health care service/facility

(a) A certificate of need is required for a transfer of ownership of the following:

1. An entire acute care hospital. Applications for such shall follow the full review process set forth at N.J.A.C. 8:33-4.1(a);

2. A transfer which will result in a new provider number for the hospitals involved in the transfer. Applications for such shall follow the full review process set forth at N.J.A.C. 8:33-4.1(a);

3. *[An acute service]* ***Acute*** care ***beds, services or equipment*** owned and/or operated by an acute care hospital. The corporate unbundling of *[an]* acute care ***beds,*** service***s or equipment*** identified in the Appendix, Exhibit 2 owned and/or operated by an acute care hospital shall require a certificate of need. Corporate unbundling refers to the transfer of ownership of *[an]* acute care ***beds,*** service***s or equipment*** owned or operated by an acute care hospital and the establishment of that service under a new corporation and under a separate license from the acute care hospital's license. Applications for such shall follow the expedited review process set forth at N.J.A.C. 8:33-4.1(b); *[and]*

4. A long-term care facility in which the proposed owner does not satisfy the Department of Health's review of the proposed owner's prior operating experience in accordance with the criteria identified in this chapter and N.J.A.C. 8:33H, as well as any requirements established by the Federal government pursuant to Titles XVIII and XIX of the Social Security Act U.S.C. 483.1 through 483.158. Applications shall follow the expedited review process set forth at N.J.A.C. 8:33-4.1(b)*[.]***;***

5. A physician who initiates a service pursuant to the grandfathering provisions of P.L. 1992, c.187 may not transfer the service without going through the certificate of need process, and except as provided for at N.J.A.C. 8:33-3.7(a)2, shall follow the expedited review process set forth at N.J.A.C. 8:33-4.1(b); and

6. The waivered status of a service is not transferable. A physician or health maintenance organization who initiates a service pursuant to the waiver provisions of P.L. 1991, c.187 may not transfer the service without approval of a waiver from the certificate of need requirements in accordance with N.J.A.C. 8:33-2.3 and 2.4 prior to the transfer. Upon approval of a waiver, application for a license shall be made in accordance with (b) below. If the application for waiver is denied, the service may not be transferred without going through the certificate of need process and shall follow the full review process set forth at N.J.A.C. 8:33-4.1(a).*

(b) A certificate of need is not required for transfer of ownership of all other operating health care facilities, beds, services or equipment not specified in (a) above. Where a certificate of need is not required pursuant to this section, application for a license on forms prescribed by the Department shall be filed with the Department's Licensing Program in the Division of Health Facilities Evaluation and Licensing, in accordance with this chapter and the Department's licensing rules.

(c)-(e) (No change in text.)

(f) These rules apply to ownership by any individual, partnership, corporation, or other entity in any entity which is the licensed operator of a facility or which owns the facility's real property. Except as otherwise provided in (h) below, a transfer of ownership which requires a certificate of need is defined as an acquisition or transfer which will increase or establish an ownership interest in a health care facility, as defined in N.J.A.C. 8:33-1.3, through purchase, lease, purchase or lease option, gift, donation, exchange, or by any other means. Types of ownership interests to which these rules apply include, but are not limited to, the following:

1.-4. (No change.)

Recodify (f)-(h) as (g)-(i) (No change in text.)

(j) Except as otherwise provided in (k) below, the transfer of approved certificates of need prior to licensure is prohibited. Proceeding with any such transfer shall nullify the certificate of need and preclude licensure as a health care facility.

(k) At the discretion of the Department, an exception to the prohibition, at (j) above, on the sale of certificates of need prior to licensure may be permitted and the certificate of need process for transfer of ownership may be allowed to proceed on an unimplemented certificate of need if the types of changes set forth at (h)1 through 6 above apply. Applicants for transfers of unimplemented certificates of need shall demonstrate in the application that the transfer will not adversely affect the financial feasibility of the project.

(l) (No change in text.)

(m) If the facility being transferred has any partially implemented or unimplemented certificate of need approvals, an application for a license to own and/or operate the facility by the new owner will not be accepted by the Licensing Program unless the current owner/operator surrenders to the Department the unimplemented certificate of need approvals. The Commissioner can waive this requirement where he or she determines that the project has been substantially completed and that completion of the project is in the public interest, consistent with the principles set forth at N.J.A.C. 8:33-1.2.

[1. The grandfathered or waivered status of a service is not transferable. A physician or health maintenance organization who initiates a service pursuant to either the grandfathering or waiver provisions of P.L. 1991, c.187 may not transfer the service without going through the certificate of need process and shall follow the full review process set forth at N.J.A.C. 8:33-4.1(a).]

8:33-3.4 Bed capacity, medical day care slot capacity

(a) The following criteria apply to changes in bed capacity.

1. Any increase in the number of licensed beds by licensure and/or health planning category requires a certificate of need and shall follow the full review process, except as follows:

i. (No change.)

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ii. Establishment of a residential health care facility requires a certificate of need and shall follow the expedited review process set forth in N.J.A.C. 8:33-4.1(b). Any increase or decrease in the bed complement of an existing licensed residential health care facility and any capital expenditures exclusively associated with the bed changes are exempt from the certificate of need requirement. However, approval from the Department's Health Facilities Construction Services prior to building construction or renovations, and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation prior to implementation of the bed changes are required, in accordance with this chapter and the Department's licensing rules.

2. Any decrease in the number of licensed beds by licensure and/or health planning category requires a certificate of need and shall follow the full review procedure where the reduction in the licensed beds will result in a capital expenditure greater than the monetary threshold specified in N.J.A.C. 8:33-3.6 or where the bed reduction would violate a condition of certificate of need approval imposed upon the provider, as determined by the Commissioner. A certificate of need will not be required for any decrease in the number of licensed beds by licensure and health planning category where the reduction can be accomplished at a total capital expenditure less than the monetary threshold specified in N.J.A.C. 8:33-3.6 and where the reduction will not violate a condition of approval of a certificate of need provided to or on behalf of the provider or the organization of which the provider entity is a part. In these instances the licensed entity will be required to notify in writing by certified mail the Certificate of Need Program and the Division of Health Facilities Evaluation in the State Department of Health at least 120 days prior to the effective date of the bed reduction identifying by number and licensure and/or health planning category the beds to be removed from the facility's license and shall specify both the total capital costs associated with the planned reduction of licensed beds and the specific plans the provider has made to relocate any and all patients occupying the beds proposed for closure. The Department will notify the provider in writing within 20 days of receipt of written notification of the proposed bed reduction whether the proposed reduction shall require a certificate of need. The provisions of this subsection shall apply exclusively to a reduction of licensed beds which results in the permanent closure of the subject beds and their removal from the facility's license. The provisions of this subsection do not apply in the case of an applicant proposing the reduction or elimination of residential health care beds or the closure of a residential health care facility. Conversions of licensed beds to other uses shall be treated as increases in the number of beds by licensure or health planning category and the provisions of (a)1 above shall apply.

3. (No change.)

(b) The following criteria apply to day health care facilities:

1. The establishment of, or an increase or decrease in the capacity of, an adult or pediatric day health care facility does not require a certificate of need. However, approval from the Department's Health Facilities Construction Services prior to building construction or renovations and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation prior to implementation of, or changes to, adult day health care facilities/services is required, in accordance with this chapter and the Department's licensing rules.

8:33-3.5 Buildings

(a) The following criteria apply to buildings:

1. Regardless of cost, a certificate of need is required for the establishment of a new health care facility and shall follow the full review process unless the facility type is specifically exempted from the certificate of need requirement pursuant to P.L.1992, c.160, section 19 (N.J.S.A. 26:2H-7a) or otherwise exempted pursuant to this chapter;

2. Replacement at the same site of an existing health care facility or relocation to a new site within the same county as the existing health care facility is exempt from the certificate of need requirement providing it meets the following criteria:

i. The facility proposed for replacement or relocation is not licensed as a general acute care hospital;

ii. The existing facility proposed for replacement or relocation is not adding beds to its total licensed bed inventory, is not adding beds within any licensure and/or health planning category at the proposed replacement or relocated facility, and is not adding any proposed new service not previously offered by the applicant at the existing facility already approved by the Department's Licensing Program in the Division of Health Facilities Evaluation;

iii. (No change.)

iv. The replacement facility shall be located at the existing site or at a new site within the same county as the existing facility. Where the new site is in a county other than the county in which the existing facility is located, a certificate of need will be required and will follow the full review process.

3. Establishment of a satellite location for a primary care center by an existing health care facility does not require a certificate of need. In these instances the licensed entity will be required to notify the Department's *[Certificate of Need Program]* ***Licensing Program in the Division of Health Facilities Evaluation*** in writing prior to establishment of a satellite location. ***If the Department determines that the proposed facility is not a satellite as defined herein,*** *[The Department will notify the provider whether]* the facility ***will*** require*[s]* a certificate of need which shall follow the full review process. The Department's final determination regarding whether a proposed facility qualifies as a satellite location in accordance with N.J.A.C. 8:25, or the establishment of a new health care facility will be a final agency decision.

4. Establishment of a new health care facility, satellite or replacement or relocation of an existing facility which is exempt from the certificate of need requirement requires approval from the Department's Health Facilities Construction Services, in accordance with the Department's licensing rules, prior to building construction or renovations and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation, in accordance with the Department's rules, prior to operation and occupancy of the beds, service or facility; and

5. Relocation *[and replacement]* of a component service of an existing health care facility will not require a certificate of need where the relocation will not result in problems of access to populations historically served and the service is not a service which is required to be a component of an inpatient health care facility. In these instances the licensed entity will be required to notify the Department's Certificate of Need Program in writing prior to relocation of the service. The Department will notify the provider whether the proposed relocation requires a certificate of need which shall follow the expedited review process in accordance with N.J.A.C. 8:33-4.1.

8:33-3.6 New construction/modernization/renovation

(a) Acquisition of a building and/or new construction, modernization or renovation of a health care facility which under generally accepted accounting principles, results in cumulative total project costs for all projects within a fiscal year in excess of $1,000,000, requires a certificate of need and shall follow the full review process unless specifically exempted from the certificate of need requirement pursuant to P.L.1992, c.160, sections 19 and 20 (N.J.S.A. 26:2H-7a and 7b). If the new construction, modernization or renovation is for a facility which provides a health care service which is the subject of a health planning regulation adopted by the Department, as defined at N.J.A.C. 8:33-1.3, then any person, including a physician or group of physicians, shall obtain a certificate of need prior to the initiation of the construction, modernization or renovation.

(b) (No change.)

(c) Mandatory replacement of fixed equipment and/or mandatory renovations to facilities in excess of the monetary thresholds for equipment replacement or renovations is exempt from the certificate of need requirement. The determination of whether the replacement of fixed equipment or renovations is mandatory as defined herein shall be made by the Commissioner. If the equipment replacement or renovations are not mandatory, a certificate of need will be required and the applicant shall follow the full review process.

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(d) Regardless of capital cost, a certificate of need is not required for new construction, modernization or renovation of a medical arts building or parking garage.

(e) Acquisition of a building; new construction, modernization or renovation of a health care facility; or acquisition of fixed equipment which is exempt from the certificate of need requirement requires approval from the Department's Health Facilities Construction Services prior to building construction or renovations and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation prior to operation and occupancy of the beds, service or facility, in accordance with this chapter and the Department's licensing rules.

8:33-3.7 Major moveable equipment

(a) Acquisition, replacement, expansion, or transfer by any person, including a physician, of major moveable equipment whose total cost exceeds $1,000,000, as well as any major moveable equipment for the provision of a service which is the subject of a health planning regulation or which is proposed by the Commissioner to be the subject of a health planning regulation, as defined at N.J.A.C. 8:33-1.3, requires a certificate of need except as follows:

1. Where the Commissioner has granted a waiver to a physician or to a Health Maintenance Organization pursuant to section 30 of P.L.1991, c.187;

2. Where a hospital acquires a magnetic resonance imager that is already in operation in the State by another health care provider or entity; *[or]*

3. Where the purchase cost for replacement of fixed or major moveable equipment by a general acute care hospital meets the criteria set forth at N.J.A.C. 8:33-6.1(b)*[.]**; **or***

4. Where the replacement of major moveable equipment by any person, including a physician, meets the criteria set forth at N.J.A.C. 8:33-6.1(c).

(b) Acquisition of an equipment unit that is part of an equipment system, through purchase, lease, or donation, if the system's cost or value, including installation and renovation under generally accepted accounting principles, results in a cumulative total project cost or value of $1,000,000 or more or is expected to be $1,000,000 or more, within a fiscal year, requires a certificate of need and shall follow the full review process in the appropriate batch, except as provided for at N.J.A.C. 8:33-6.1(b).

(c) (No change.)

(d) Optional replacement of existing major moveable equipment with the same equipment which exceeds the dollar threshold or which is the subject of a health planning regulation requires a certificate of need and shall follow the full review process in the appropriate batch, except as provided for at N.J.A.C. 8:33-6.1(b).

(e) Mandatory replacement of major moveable equipment as defined at N.J.A.C. 8:33-1.1, is exempt from the certificate of need requirement. The determination of whether the replacement equipment is mandatory as defined herein shall be made by the Commissioner. If the equipment replacement is not mandatory, a certificate of need will be required and shall follow the full review process, in accordance with N.J.A.C. 8:33-6.1.

(f) Acquisition, replacement, expansion, or transfer of major moveable equipment which is exempt from the certificate of need requirement requires approval from the Department's Health Facilities Construction Services prior to building construction or renovations and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation prior to operation of the service, in accordance with this chapter and the Department's licensing rules.

8:33-3.8 Minor moveable equipment

Regardless of capital cost, a certificate of need shall not be required for the acquisition, replacement, expansion or transfer by any person, including a physician, of minor moveable equipment.

8:33-3.9 Changes in cost/scope/financing

(a) Any proposed change in the cost of an approved project shall require a change of cost review and shall follow the expedited review process outlined in N.J.A.C. 8:33-5, except as follows:

1. A certificate of need for change in the cost for an original certificate of need approval issued after September 8, 1992 may not exceed 10 percent of the approved capital cost plus any construction cost factor calculated by the Department for the life of the certificate of need. Any certificate of need application for change in cost which exceeds 10 percent will not be accepted for processing.

2.-3. (No change.)

(b) The following criteria apply to a proposed change in the location of an approved, but unimplemented, certificate of need project:

1. Relocation of the proposed project within the same county does not require a certificate of need review. The applicant shall submit written notification to the Certificate of Need Program and the Division of Health Facilities Evaluation with appropriate documentation of site control. Relocation of a proposed project which is exempt from the certificate of need requirement requires approval from the Department's Health Facilities Construction Services prior to building construction or renovations and approval from the Department's Licensing Program in the Division of Health Facilities Evaluation prior to operation and occupancy of the beds, service or facility, in accordance with this chapter and the Department's licensing rules.

2. Relocation of the proposed project outside the approved county will not be accepted for processing. Failure of the applicant to implement the project within the same county will result in nullification of the approved certificate of need.

(c)-(f) (No change.)

(g) Any change in financing or change in the method of financing which will result in an increase in capital-related operating costs of 10 percent or more shall be considered a change in financing and shall follow the expedited review process. Wherever the refinancing will not result in an increase in capital-related operating costs of 10 percent or more and, in the case of general acute care hospitals, will not cause a hospital to exceed its maximum capital cost per admission allowance under the State's hospital reimbursement system), no certificate of need for a change in financing shall be required. The Department will, however, require written notification from the approved applicant of the change that was effectuated through an approved refinancing within 30 calendar days of securing the refinancing.

(h) (No change.)

8:33-3.10 Duration of certificate of need

(a) The following criteria apply to the duration of a certificate of need:

1. For a certificate of need approved after September 8, 1992, the certificate of need shall be valid for a period of five years from the date of approval. Unless the State Health Plan specifies a different period of time for which a certificate of need for that service shall be valid or under exceptional circumstances, the Commissioner may grant additional time in the initial certificate of need approval letter for completion of a project. The applicant will be required to petition for the extended period of time in its application, providing a detailed schedule for project implementation and identifying a specific time frame for project completion.

i. (No change.)

2. For a certificate of need approved prior to September 8, 1992, the certificate of need approval shall remain valid until the expiration date noted in the most recent extension of time. The applicant will be required to file for an extension of time 60 days prior to the current expiration and to propose a detailed time frame identifying the remaining time needed to complete the approved subject. Where the Commissioner determines that the approval should be extended for an additional period of time beyond its current expiration date, he or she will assign a final expiration date.

8:33-3.11 Demonstration and research projects

(a)-(b) (No change.)

(c) At the conclusion of the research project, the health care services and equipment provided in the course of the research will no longer have certificate of need exemption status. At that time, if the services and equipment used are to be continued such that they will be provided to the general population or where billings

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for such services or equipment shall occur or reimbursement received, a certificate of need must be obtained in accordance with he provisions of this chapter and all other applicable health planning regulations.

8:33-4.1 Request for certificate of need applications

(a) The full review process involves the review of a certificate of need application by the local advisory board(s) and the State Health Planning Board, as well as the Department of Health. The full review process for certificate of need applications will be activated upon notice by the Commissioner inviting certificate of need applications for specific services. The notice shall become effective upon the date of publication in major newspapers of general circulation in the State. The notice will also be distributed to health care associations on file with the Department, filed with the Office of Administrative Law and published in the New Jersey Register. Beginning in calendar year 1993 the Commissioner shall publish in the New Jersey Register in February of each year an anticipated schedule for receipt of certificate of need applications subject to full review procedures during the current calendar year. The Commissioner may announce additional or special calls for certificate of need applications beyond those identified in the yearly notice or may delete announced calls from the yearly notice. Wherever practical, the Commissioner shall provide notice in accordance with this section to allow for a minimum of 90 days between the date of publication of the Commissioner's notice inviting certificate of need applications and the date for submission of applications in response to the notice(s). The notice will identify the needed service(s), proposed geographic area(s) to be served, the date the application is due, the date the application is deemed complete for processing, the date the local advisory board must submit its recommendation to the Commissioner and the date that the State Health Planning Board must submit its recommendation to the Commissioner. The local advisory board(s) shall forward recommendations to the State Health Planning Board and Commissioner within 45 days after the application is deemed complete for processing and the State Health Planning Board shall forward recommendations to the Commissioner within 90 days after the application is deemed complete for processing unless a fair hearing is requested by an applicant in accordance with the procedures identified at N.J.A.C. 8:33-4.14. A decision should generally be rendered by the Commissioner approximately three months after the application is deemed complete for processing.

(b) (No change.)

8:33-4.9 General criteria for review

(a) The State Health Planning Board shall prepare and revise annually a State Health Plan. The State Health Plan shall identify the unmet health care needs in an area by service and location and it shall serve as an advisory document which may be considered when certificate of need applications are reviewed for approval. The State Health Planning Board shall consider the recommendations of the local advisory boards in preparing and revising the plan to incorporate specific regional and geographic considerations of access to, and delivery of, health care services at a reasonable cost. The State Health Planning Board shall incorporate the recommendations of the local advisory boards into the plan unless the recommendations are in conflict with the best interests of Statewide health planning. If any recommendations of the local advisory boards are not incorporated into the plan, the State Health Planning Board shall identify those recommendations, which shall be listed separately for each local health planning region, in an addendum to the plan and shall state the specific reason that each recommendation is in conflict with the best interests of Statewide health planning.

(b) No certificate of need shall be issued unless the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health care services in the region or Statewide, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration:

1.-6. (No change.)

(c) It shall be the responsibility of the applicant to adequately and appropriately demonstrate that the proposed project meets the standards set forth in (b) above. It is not incumbent upon the reviewing agencies to demonstrate lack of need.

(d) (No change.)

(e) For the three-year period beginning January 1, 1992 through December 31, 1994, the Commissioner shall limit approval of certificates of need for hospitals for capital construction projects that would be financed by the New Jersey Health Care Facilities Financing Authority to a Statewide total of $225,000,000 per year for all projects, exclusive of the refinancing of approved projects.

1. (No change.)

2. The annual cap shall include the total project cost of each approved certificate of need for acute care hospitals including the following:

i.-iii. (No change.)

iv. The cap shall not apply to a certificate of need application which is funded totally by cash equity.

3.-4. (No change.)

8:33-4.10 Specific criteria for review

(a) Each applicant for a certificate of need must show how the proposed project will promote access to low income persons, racial and ethnic minorities, women, disabled persons, the elderly, and persons with HIV infections and other persons who are unable to obtain care. In determining the extent to which the proposed service promotes access and availability to the aforementioned populations, the applicant, where appropriate, shall address in writing the following:

1. The contribution of the proposed service in meeting the health related needs of members of medically underserved groups as may be identified in the applicable local health plan and State health planning regulations as deserving of priority;

2.-9. (No change.)

(b) Each applicant for certificate of need shall demonstrate that the proposed project can be economically accomplished and maintained; that it will address otherwise unmet needs in a particular municipality, county, and/or regional health planning area; that it will not have an adverse economic or financial impact on the delivery of health care services; and that projected volume is reasonable. Evaluation of the applications will include a review of:

1.-5. (No change.)

6. The immediate and long-term financial impact on the institution this review will assess:

i.-vi. (No change.)

vii. The feasibility of refinancing both new and existing debt. When it is economically feasible, the applicant must agree to refinance; and

viii. The ability of acute care hospitals to meet the operating costs associated with the project; and

7. (No change.)

(c)-(d) (No change.)

(e) Each applicant for certificate of need shall demonstrate character and competence, qualify of care, and an acceptable track record of past and current compliance with State licensure requirements, applicable Federal requirements, and State certificate of need requirements, including, but not limited to, the following:

1. (No change.)

2. Applicants shall demonstrate the capacity to provide a quality of care which meets or surpasses the requirements contained in the applicable licensing standards for the facility. Evidence of the capacity to provide high quality care shall include (e)2i below and may if applicable, also include (e)2ii-iv below:

i. A satisfactory record of compliance with licensure standards in existing health care facilities which are owned, operated, or managed, in whole or part, by the applicant. This may include reports issued by licensing agencies from other states, as well as from the Department;

ii. Narrative descriptions or listings within the application of services, staffing patterns, policies and protocols addressing delivery of nursing, medical, pharmacy, dietary, and other services affecting residents' quality of care;

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iii. Documentation of compliance with the standards of accreditation of nationally-recognized professional bodies; and

iv. Where applicable, a recommendation by the State Department of Human Services' Division of Medical Assistance and Health Services and Division of Mental Health and Hospitals regarding the quality of and access to services provided by the applicant to Medicaid patients and patients who have been discharged from State and county psychiatric hospitals;

3. The Department shall examine and evaluate the licensing track record of each applicant for the period beginning 12 months preceding submission of the certificate of need extending to the date the Commissioner issues a final decision, for the purpose of determining the capacity of an applicant to operate a health care facility in a safe and effective manner in accordance with State and Federal requirements. A certificate of need application may be denied where an applicant has not demonstrated such capacity, by evidence of any continuing violation or a pattern of violations of State licensing standards or Federal certification standards at any health care facility in which the applicant has or has had an ownership or managerial interest. ***An application also may be denied where an applicant has violated any State licensing or Federal certification standards in connection with an inappropriate discharge or denial of admission.*** An applicant, for purposes of this Chapter, includes any person, partner, and/or corporation which is an owner, principal, operator or manager of the proposed or existing licensed health care facility which is seeking certificate of need approval;

4. A certificate of need submitted by an applicant who was cited for any State licensing or Federal certification deficiency during the period identified in (e)3 above, which represented *[an inappropriate discharge or denial of admission or]* a serious risk to the life, safety, or quality of care of the facility's patients or residents, shall be denied. A serious risk to life, safety, or quality of care of patients or residents includes, but is not limited to, any deficiency in State licensure or Federal certification requirements in the areas of nursing, patient rights, patient assessment of care plan, dietary services, infection control and sanitation, or pharmacy*[. In no case shall a certificate of need be approved if the State licensing or Federal certification action results in]* ***resulting in***:

i. An action by a State or Federal agency to curtail or temporarily suspend admissions to a facility; or

ii. In the case of long term care, a finding of two or more Level A violations as a result of one survey, or one or more Level A violations of the same type on consecutive surveys;

5. In evaluating track record pursuant to (e)3 or 4 above, the Department may cnsider any evidence of noncompliance with applicable licensure requirements provided by an official state licensing agency in any state outside of New Jersey, or any official records from any agency of the State of New Jersey indicating the applicant's non-compliance with the agency's licensure or certification requirements in a facility the applicant owned, operated, or managed in whole or in part.

Recodify existing 2.-3. as 6.-7. (No change in text.)

8:33-4.12 Functions of local advisory boards

(a) (No change.)

(b) The local advisory board shall review certificate of need applications for proposed projects in its region and make recommendations to the Commissioner in consideration of the State Health Plan and consistent with all appropriate health planning regulations.

(c) (No change.)

(d) The local advisory board shall be responsible for the following activities:

1. (No change.)

2. Written notification to its service area public of the beginning of a review, which shall include notification of the proposed schedule for the review, the public comment period for persons directly affected by the review, and the manner in which public comment will be received, that is, through written comment or oral testimony; and

3. Evaluation of the public need for each proposal in consideration of the State Health Plan, the criteria for review identified in N.J.A.C. 8:33-4.9 and 4.10 and in accordance with the requirements of applicable State health planning regulations.

(e) (No change.)

8:33-4.13 Role of the State Health Planning Board

(a) The State Health Planning Board shall review applications for certificates of need and make recommendations to the Commissioner in consideration of the State Health Plan and in accordance with all applicable health planning regulations.

(b)-(c) (No change.)

8:33-4.16 Conditions on approval/monitoring

(a) (No change.)

(b) Any conditions placed on a certificate of need approval shall become part of the licensure requirements of the approved facility. Failure to comply with approved certificate of need conditions may result in licensure action by the Department and may constitute an adequate basis for denying certificate of need applications by an applicant who is out of compliance with conditions on previous approvals. The applicant must contest any condition, if at all, within 30 days of receipt of notice. The applicant will vacate his right to oppose said condition(s) if he fails to submit written notice that he contests any condition to the Department within this time. If the applicant contests a condition, the Commissioner will suspend his or her approval of the certificate of need in order to consider the objection. Furthermore, the Commissioner has the right to nullify the approval of the certificate of need. The Commissioner may, at his or her discretion, consult with the State Health Planning Board to obtain its recommendation on the contested condition(s).

(c) When conditions are included in the Commissioner's approval letter, the applicant shall file a progress report on meeting such conditions with the Certificate of Need Program at least 12 months from the date of approval and annually for the first two years after project implementation and at any other time requested by the Department in writing. Failure to file such reports may result in the nullification of the approved certificate of need, fines and penalties imposed through licensure action and/or taken into consideration in the review of subsequent certificate of need applications.

(d) (No change.)

8:33-5.1 Statement of purpose

(a) The expedited review process shall be used for the following specific applications:

1. Establishment of residential health care facilities;

2. Establishment of a restricted admissions facility or change in bed capacity of a restricted admissions facility;

3. Change in cost to an original certificate of need issued after September 8, 1992 which is 10 percent or less of the approved capital cost including an inflation factor;

4. Change in cost to an original certificate of need issued prior to September 8, 1992; and

5. Establishment of or changes in the capacity of comprehensive personal care homes, in accordance with the requirements of this chapter and the Department's licensing rules;

(b) (No change.)

8:33-5.4 Specific requirements

(a) In addition to the requirements of N.J.A.C. 8:33, the following information shall be provided, as appropriate, for all expedited review projects:

Recodify existing 2.-4. as 1.-3. (No change in text.)

8:33-5.5 (Reserved)

SUBCHAPTER 6. CERTIFICATE OF NEED EXEMPTIONS

8:33-6.1 Statement of purpose

(a) In accordance with the provisions of the Health Care Reform Act, P.L. 1992, c.160, the following specific health care services or projects are exempt from the certificate of need requirement:

1. Community-based primary care centers, as defined at N.J.A.C. 8:33-1.3, which provide preventive, diagnostic, treatment, manage-

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ment, and reassessment services exclusively on an outpatient basis to individuals with acute or chronic illnesses in a location and manner that is accessible to individuals;

2. Outpatient drug and alcohol services which include drug-free and methadone maintenance services and day treatment alcohol services;

3. Ambulance and invalid coach services excluding mobile intensive care unit services;

4. Mental health services which are non-bed related outpatient services including outpatient centers, partial hospitalization programs and case management programs;

5. Increases or decreases in the bed capacity of residential health care facilities;

6. Mandatory renovations to existing facilities;

7. Mandatory replacement of fixed or moveable equipment;

8. Transfer of ownership interest, except in the case of a general acute care hospital, or a long-term care facility in which the ***new*** owner does not satisfy the Department of Health's review of the ***new*** owner's prior operating experience in accordance with the criteria identified at N.J.A.C. 8:33-4.10 and N.J.A.C. 8:33H, as well as any requirements established by the Federal government pursuant to Titles XVIII and XIX of the Social Security Act (USC 483.1 through 483.158).

9. Change of site for an approved certificate of need within the same county;

10. Relocation or replacement of a health care facility within the same county, except for a general acute care hospital;

11. Continuing care retirement communities authorized pursuant to P.L. 1986, c.103 (N.J.S.A. 52:27D-330 et seq.) which contain a minimum of four independent living units for every one long-term care bed;

12. Acquisition by a general acute care hospital of a magnetic resonance imager that is already in operation in the State by another health care provider or entity;

13. Adult day health care facilities;

14. Pediatric day health care facilities; and

15. Chronic renal dialysis facilities.

(b) In accordance with the provisions of the Health Care Reform Act, P.L. 1992, c.160, section 20 (N.J.S.A. 26:2H-7b), modernization, renovation, and/or replacement of fixed or major moveable equipment by a general acute care hospital shall be exempt from the certificate of need requirement providing it meets the following criteria:

1. Where the total project or purchase cost does not exceed five percent of that hospital's operating revenues for the year in which the project or purchase is undertaken, a certificate of need is not required.

i. For purposes of this subsection the total project is defined as the compilation, during a single calendar year, of architectural, engineering and/or construction services for renovations provided by individuals or firms which are not employees of the hospital and for which financing is required to fund the project.

ii. For purposes of this subsection, if the hospital incurs capital expenditures without use of the external services as described above, then each planned renovation of any discrete area or unit of the hospital shall be considered a separate project.

iii. For purposes of this subsection, purchase cost is defined as the cost of acquisition of a single unit of fixed or major moveable equipment, including installation and renovation.

iv. For purposes of this subsection, operating revenues will be defined as total operating revenues from the hospital's most recent year audited financial statements, which will be inflated using a global economic factor which measures the change in the prices of goods and services used by New Jersey hospitals.

2. This exemption shall not apply to the initiation or expansion of any health care service as provided in section 2 of P.L. 1971, c.136 (N.J.S.A. 26:2H-2), as amended, which includes a health care service that is identified in the Appendix, Exhibit 2, the expansion of a hospital's physical plant; or the construction of a new health care facility.

***(c) Replacement of major moveable equipment by any person, including a physician, shall be exempt from the certificate of need requirement providing it meets the following criteria:**

1. The total purchase cost including installation and renovation is $1,000,000 or less; and

2. The replacement maintains existing capability and does not include upgrading to a newer technology that expands the range of service.*

8:33-6.2 Process

(a) This section shall apply to projects which are exempt from the certificate of need requirement.

(b) For mandatory replacement of fixed or major moveable equipment or mandatory renovations to existing facilities, an explanation of the mandatory nature, including a written opinion regarding hazards and safety effects upon patient care by experienced professionals, or from Federal, State, county or municipal governmental agencies shall be submitted to the Commissioner of Health for a determination prior to proceeding with the replacement or renovations.

(c) For community-based primary care centers not specifically identified herein, a description of the proposal, including services to be offered, staffing, population to be served and anticipated revenue sources, shall be submitted to the Commissioner of Health for a determination regarding certificate of need requirements prior to proceeding with initiation of services at the proposed facility, in accordance with the provisions of this chapter.

(d) For continuing care retirement communities, a certificate of authority from the Department of Community Affairs for the operation of a continuing care retirement community shall be submitted to the Department of Health prior to licensure of the long-term care beds.

(e) Written notification and architectural plans shall be submitted to the Department's Health Facilities Construction Services for approval prior to initiating building construction or renovations, in accordance with this chapter and the Department's licensing rules.

(f) Written notification shall be submitted to the Department's Licensing Program in the Division of Health Facilities Evaluation for approval prior to operation and occupancy of the beds, service or facility in accordance with this chapter and the Department's licensing rules.

(g) Application for a license on forms prescribed by the Department shall be filed with the Department's Licensing Program in the Division of Health Facilities Evaluation for approval prior to any transfer of ownership of beds, service or facility, in accordance with this chapter and the Department's licensing rule.

APPENDIX

EXHIBIT 1 (No change)

EXHIBIT 2

HEALTH CARE SERVICES

A. Bed-related

1. Medical/Surgical
2. Obstetrics, gynecology
3. Pediatric
4. Adult and pediatric intensive or critical care
5. Cardiac care
6. Comprehensive rehabilitation
7. Long-term care and specialized long-term care
8. Residential health care
9. Adult acute psychiatric (open and closed)
10. Adult intermediate and special psychiatric
11. Child and adolescent acute psychiatric
12. Child and adolescent intermediate psychiatric
13. Alcohol detoxification
14. Alcohol residential treatment
15. Drug free residential

[16. Orthopedic]

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B. Non-bed related
1. Home health agency
2. Comprehensive outpatient rehabilitation facility
3. Surgical facility
4. Special child health clinics providing tertiary services

C. Special Services
1. Acute renal dialysis
2. Invasive cardiac diagnostic services
3. Burn center, unit or program
4. Cardiac surgical services
5. Organ transplant/organ procurement
6. Megavoltage radiation oncology
7. Organ bank
8. Perinatal services including neonatal intensive or intermediate services and maternal and child health consortia
9. Mobile intensive care or advanced life support services
10. Position emission tomography services
11. Magnetic resonance imaging and nuclear magnetic resonance services
12. Extracorporeal shock wave lithotripsy services
13. Birthing centers
[14. Abortion services]
*[15.]**14.* Comprehensive personal care home
*[16.]**15.* Assisted living residence
*[17.]**16.* Bone marrow transplant/harvesting
*[18.]**17.* Trauma services
*[19.]**18.* Children's hospitals
*[20.]**19.* Hyperbaric chambers
*[21.]**20.* Emergency medical service helicopters
*[22.]**21.* Central service agency
*[23.]**22.* Any service for which regionalization criteria or health planning regulations have been developed.
*[24.]**23.* Other new health/medical care technologies including any medical equipment which has received FDA pre-marketing approvals.

EXHIBIT 3. (No change.)

(a)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

Ambulatory Care Facilities
Standards for Licensure
Readoption with Amendments: N.J.A.C. 8:43A
Repeal and New Rules: N.J.A.C. 8:43A-1 through 11 and 8:43A-13 through 19
New Rules: N.J.A.C. 8:43A-20 through 29

Proposed: March 1, 1993 at 25 N.J.R. 757(b)

Adopted: August 16, 1993, by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: August 16, 1993 as R.1993 d.443, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Effective Date: August 16, 1993, Readoption;
September 7, 1993, Repeals and New Rules.
Expiration Date: August 16, 1998.

Summary of Public Comments and Agency Responses:

The Department received 27 letters of comment in response to the proposal. These included letters from representatives of nine associations or organizations, from representatives of 13 facilities or groups of facilities, from the Department of Human Services, and from one individual. Associations and organizations included the following: the New Jersey Hospital Association; the New Jersey Family Planning League, Inc.; the Family Planning Association of New Jersey; the New Jersey Pharmaceutical Association; the New Jersey Academy of Consultant Pharmacists; the Joint Board for Certification of Consultant Pharmacists; the Radiological Society of New Jersey; the Southern New Jersey Perinatal Cooperative; and the National Association of Childbearing Centers. Facilities and groups of facilities included the following: Burlington County Dialysis Center; National Medical Care, Inc.; the Stone Center of New Jersey; Community Medical Center; the Valley Hospital; Newton Memorial Hospital; Newark Beth Israel Medical Center; Kessler Rehabilitation Corporation; MRI of Northern New Jersey; Planned Parenthood of Greater Northern New Jersey, Inc.; Planned Parenthood of Monmouth County, Inc.; Planned Parenthood of Passaic County, Inc.; and South Jersey Urologic Associates, P.A. The individual commenter was Solomon Goldberg, DDS.

General Comments

COMMENT: Newton Memorial Hospital recommended that "an additional thirty (30) to sixty (60) days for comment be allowed to provide hospitals with the opportunity to evaluate the impact of these regulations upon their operations."

RESPONSE: On the basis of the number of letters submitted, the depth of the comments contained therein, and the diverse types of facilities represented by the respondents, the Department has concluded that ample notice has been provided and ample time afforded for reviewing and responding to the notice of proposal. Consequently, the comment period has not been extended beyond the standard 30-day period.

N.J.A.C. 8:43A-1.1

COMMENT: The Valley Hospital stated that, contrary to the perceived intent of the proposed rules, it appears that the proposed rules would fail to extend to all ambulatory facilities, such as some of those providing surgical or MRI services, since these facilities may have only one operating room or may be considered the private practice of medicine. It was stated that some entities with one operating room are facilities in actuality. It was suggested that the definition of "ambulatory care facility" could be based on "the type of and manner in which services are rendered." In contrast, the Radiological Society of New Jersey recommended that the rules specifically exclude private practices in which radiologists "have offices specifically established to provide diagnostic services, to include CT and MRI," given recent health care legislation.

RESPONSE: N.J.S.A. 26:2H-5 authorizes the Department to promulgate standards relating to the licensing of "health care facilities," as defined at N.J.S.A. 26:2H-1 et seq. The Department maintains that there is a distinction between a health care facility and a private medical practice and has attempted to limit the applicability of the proposed rules to the former, as the private practice of medicine is regulated by the New Jersey State Board of Medical Examiners. In this effort, the Department is guided by the dictates of State statute and other Departmental rules and guidelines.

The Department interprets P.L. 1992, c.160, and its predecessor, P.L. 1991, c.187, as defining the basic parameters of the private practice of medicine insofar as it is exempt from both Certificate of Need requirements and ambulatory care facility licensure. Under the law, private physician practices require a Certificate of Need when they are initiating or providing a health care service which (1) is the subject of a health planning regulation adopted by the Department of Health, (2) is a health care service enumerated in N.J.S.A. 26:2H-2, or (3) involves the purchase of major moveable equipment the total cost of which is greater than $1,000,000. Chapter 187 provides a further exemption for physicians who contracted for major moveable equipment prior to July 1, 1991, subject to certain limitations.

By concurrent action, the Department is clarifying the circumstances in which a private practice exemption applies to surgical services within the Certificate of Need: Surgical Facilities rules (N.J.A.C. 8:33A), and generally within the Certificate of Need: Application and Review Process rules (N.J.A.C. 8:33). The Department will require any entity not qualifying for the private practice of medicine exemption which provides surgical or other services within the scope of the proposed rules, as delineated at N.J.A.C. 8:43A-1.1, to obtain a license to operate as a health care facility.

COMMENT: A number of commenters questioned the applicability of the proposed rules to on-site hospital outpatient departments and requested clarification. It was noted that such departments, which could include emergency departments, would be subject to multiple sets of licensure standards. This redundancy could lead to confusion, excessive

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administrative burden, and higher cost. Newton Memorial Hospital recommended that the rules be limited to "freestanding, non-hospital based ambulatory services." A similar comment was made by Newark Beth Israel Medical Center.

RESPONSE: The Department, too, sees the possibility of duplication of regulation with respect to hospital-based outpatient services if the entire manual of standards for ambulatory care facilities were to apply. The Hospital Licensing Standards at N.J.A.C. 8:43G, however, currently do not adequately address hospital outpatient departments, thus the Department's decision to retain applicability of the ambulatory care manual to the hospital setting.

The Department will develop and propose amendments to the Hospital Licensing Standards in order to address outpatient departments which are under the license of the hospital. These would include all ambulatory care departments operating within or in areas contiguous with the premises of the hospital. All ambulatory care services provided off-site would still need to be provided through a facility licensed under N.J.A.C. 8:43A. Once the hospital rules are amended, these ambulatory care rules will be amended accordingly.

COMMENT: Kessler Institute for Rehabilitation and Wellkind Rehabilitation Hospital requested definition and clarification of "outpatient physical therapy" and "rehabilitation agencies." The distinction between outpatient physical therapy centers which would or would not be subject to these rules needs to be clearly delineated.

RESPONSE: The manual, and hence licensure as an ambulatory care facility, is intended to apply to facilities which are eligible for certification as comprehensive outpatient rehabilitation facilities in accordance with Federal rules (42 CFR Part 485, Subpart B). It is not intended to apply to private practitioners or to less than comprehensive facilities which provide, for example, a single component of comprehensive rehabilitation. In the interest of clarity, a definition of "comprehensive rehabilitation agency" was added at N.J.A.C. 8:43A-1.3. Furthermore, N.J.A.C. 8:43A-1.1 and 2.3(a)9 were revised so as to consistently refer to "comprehensive rehabilitation" agencies or services.

N.J.A.C. 8:43A-1.3

COMMENT: One commenter suggested the possibility of including "family planning agencies" under the definition of "community based primary care services" on the basis of the implications which this action would have with respect to certificates of need. It was further suggested that, in accordance with the State Health Plan, "reproductive health services" be defined as "all of the health services related to fertility which include but are not limited to: preconceptual care, perinatal care, family planning services, sterilization, prevention and treatment of sexually transmitted diseases, abortion services, adoption options counseling, infertility counseling, and education and information on all of the above."

RESPONSE: The terms "family planning services" and "primary care" are defined separately for the purposes of this licensure manual. The Department, however, concurs that family planning agencies may be considered community-based primary care centers and is amending N.J.A.C. 8:33, Certificate of Need: Application and Review Process, accordingly.

The definitions in N.J.A.C. 8:43A-1.3 serve to impart the intended meaning to the rules throughout the manual in which the defined terms appear. Alteration of the definitions in such a way as to address certificate of need issues could, in this case, substantially and detrimentally affect the efficacy of rules in other subchapters. In addition, the Department believes that the components of comprehensive reproductive health care services listed within the proposed definition of "family planning services" adequately serve the purpose of this definition. The definitions were not rewritten in the manner requested. Both the definition of "family planning services" at N.J.A.C. 8:43A-1.3 and the rule at N.J.A.C. 8:43A-2.3(a) have been revised in order to clarify that the scope of a family planning agency does not include abortion services. Although the Department is acting within the certificate of need rules to define introduction of abortion services as community-based primary care, prior authorization and review to ensure that the minimum standards of care are met are required for licensure purposes.

COMMENT: The Radiological Society of New Jersey recommended that "health care facility" be defined as "a facility so defined in N.J.S.A. 26:2H-1 et seq., licensed by the New Jersey Department of Health and not the private practice of medicine."

RESPONSE: The definition of "health care facility" in N.J.A.C. 8:43A-1.3 cross references the corresponding definition in N.J.S.A. 26:2H-1 et seq., which is the authorizing statute for the licensure rules. The Department perceives no need to expand on the definition in the statute; hence the definition was not rewritten.

COMMENT: Kessler Institute for Rehabilitation and Welkind Rehabilitation Hospital recommended that, in accordance with the intent expressed in the proposed Summary, the definition of "satellite" be revised so as to include satellites of licensed comprehensive rehabilitation hospitals with outpatient services.

The commenter also requested addition of qualifications for occupational therapists, physiatrists, physical therapists, psychologists, and speech-language pathologists from the Manual of Standards for Licensure of Rehabilitation Hospitals, N.J.A.C. 8:43H.

RESPONSE: A "satellite," for the purposes of this chapter, must be a satellite of a separately licensed ambulatory care facility—not an affiliate of a different type of health care facility. If the outpatient service of the comprehensive rehabilitation hospital is licensed as an ambulatory care facility, however, then it can support one or more satellites. The definition was not rewritten in the manner requested.

The various staff qualifications which the commenter recommended be added refer to personnel not otherwise identified in the chapter. Addition of such requirements, therefore, would be without any regulatory import. For this reason, the qualifications were not added.

N.J.A.C. 8:43A-1.27

COMMENT: National Medical Care, Inc., requested that the rule be revised so as to reflect the actual role of a social worker with an MSW degree in a freestanding, non-hospital based dialysis facility. A social worker with a BSW degree could perform the routine, clerical tasks. The social worker with an MSW degree should be contractually employed to supervise, to approve care plans, and to provide direct consultative services.

RESPONSE: The specified qualifications allow for both certified (baccalaureate degree) and licensed (master's degree) social workers. Where a situation calls for a person with a master's degree in social work, the rule explicitly indicates the need for a "licensed social worker." N.J.A.C. 8:43A-24.3(c) of the subchapter on chronic dialysis exemplifies this approach. Consequently, the rule was not rewritten in the manner requested.

N.J.A.C. 8:43A-2.2

COMMENT: Newark Beth Israel Medical Center stated that hospitals with existing ambulatory care programs should not be required to "resubmit for licensure for their ambulatory care programs." The rule should apply to new programs and new certificate of need determinations.

RESPONSE: The applicability of N.J.A.C. 8:43A to hospital outpatient services is not new but, rather, has been the case since 1985. Consequently, adoption of the new rules should not result in numerous new applications from existing hospital outpatient services. The Department has, in fact, licensed all off-site hospital outpatient centers which have been reported to the Department and cannot exempt those established without licensure. Licenses will still need to be renewed annually, and N.J.A.C. 8:43A-2.3(d) explains the way in which licensure information will be updated upon annual renewal of the license.

N.J.A.C. 8:43A-2.3(a)

COMMENT: Community Medical Center stated that all freestanding radiation therapy centers should be required to be licensed as ambulatory care facilities and, therefore, "therapeutic radiology services" should be added to N.J.A.C. 8:43A-2.3(a).

RESPONSE: The Department generally agrees, but will need to defer adding therapeutic radiology services to the scope of the rules until a later date. Such an addition would require the development of specific standards and a formal notice of proposal.

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N.J.A.C. 8:43A-2.3(a)9

COMMENT: Kessler Institute for Rehabilitation and Welkind Rehabilitation Hospital requested clarification of which facilities providing physical rehabilitation services would need to be licensed in accordance with this rule.

RESPONSE: As noted above, the manual is intended to apply to facilities which are eligible for certification as comprehensive outpatient rehabilitation facilities in accordance with Federal rules (42 CFR Part 485, Subpart B). In the interest of clarity, a definition of "comprehensive rehabilitation agency" was added at N.J.A.C. 8:43A-1.3. Also, N.J.A.C. 8:43A-1.1 and 2.3(a)9 were revised so as to consistently refer to "comprehensive rehabilitation" agencies or services.

N.J.A.C. 8:43A-2.3(e)

COMMENT: Newark Beth Israel Medical Center suggested that, in order to avoid delay in obtaining authorization to establish new services, institutions should be permitted to add a service but should then be reevaluated at the time of licensure renewal.

RESPONSE: The rule was not rewritten in the manner suggested. The Department holds that prior authorization would help to ensure patient health and safety, since such authorization would depend upon compliance with the rules and could depend upon the results of an on-site inspection. In the absence of a requirement for prior authorization, a new service could operate for up to one year without meeting these minimum standards.

N.J.A.C. 8:43A-2.6(b)

COMMENT: Newark Beth Israel Medical Center stated that licenses should be granted for a period of not less than three years and should be consistent with Joint Commission standards. Alternatively, the time period should be "consistent with time period for inspection of the facility by the Department of Health."

RESPONSE: The Department issues annual licenses for the various types of licensed health care facilities under the authority of N.J.S.A. 26:2H-12, which specifies a maximum one-year period for licensure. This mandate is implemented by the Department to the extent staffing permits by a survey of each facility. Since the Joint Commission's accreditation process is voluntary and the Department of Health licensure requirements are distinct and independent, there is no need for the frequencies of the respective inspections to be the same. The rule was not rewritten.

N.J.A.C. 8:43A-3.1

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey stated that the rule should not apply to facilities limited to the provision of CT, MRI, or other radiological services. Also, "the diagnostic center should not be required to have a written agreement with another entity for services it does not provide."

RESPONSE: The Department has determined that the rule should apply to the facilities described by the commenter, with the exceptions noted at N.J.A.C. 8:43A-25.1(a)3 concerning provision of nursing services in the facility and at N.J.A.C. 8:43A-25.1(a)7 concerning counseling services. The requirement at N.J.A.C. 8:43A-3.1(b) is intended to refer to services which are provided by a party other than the facility, but which may be provided either inside or outside of the facility. The Department contends that the required elements of the written agreement are minimal, appropriate for the situations described, and necessary. The rule was not rewritten in the manner suggested.

N.J.A.C. 8:43A-3.3(a)

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey stated that the rule as written "would create an unnecessary administrative burden for both the ambulatory care facility and the Department." The facility should only have to notify the Department if a change in ownership affects more than 10 percent of the whole.

RESPONSE: The requirement for providing the Division of Health Facilities Evaluation and Licensing with prior written notification of changes in ownership is specified at N.J.A.C. 8:33-3.3, Certificate of Need: Application and Review Process, Transfer of a Health Care Service/Facility. The rule specifically addresses purchase or sale of less than 10 percent of the outstanding stock in a business corporation. The reported changes in ownership, however, are not subject to review or approval by the Division. The rule was not rewritten.

N.J.A.C. 8:43A-3.4(b)

COMMENT: Newark Beth Israel Medical Center noted that there would be "needless costs associated with compiling and maintaining" the information on distinct patients required by the rule, as opposed to data on patient visits. The rule would place an unnecessary burden on smaller facilities, since computer capability might be needed.

RESPONSE: The Department does not agree that the rule as proposed would result in needless costs to facilities. Although the rule calls for the collection and submission of aggregate data indicative of the number of distinct patients served, it does not require the potentially more costly reporting of information on individual patients. The Department maintains that the value of the statistical data justifies the effort necessary to maintain an accounting of unique individuals served.

N.J.A.C. 8:43A-3.5(e)

COMMENT: The Valley Hospital commented that this rule concerning basic cardiac life support need not apply, for example, to facilities which provide only counseling services, and the rule, therefore, should be revised.

RESPONSE: Though the Department recognizes the differences in health status of the various patient populations served by the various types of ambulatory care facilities, as evidenced by the modified nurse staffing requirement at N.J.A.C. 8:43A-26.4 for drug abuse treatment facilities, the Department maintains that N.J.A.C. 8:43A-3.5(e) represents the minimally necessary measure which needs to be taken by a health care facility actively serving patients in order to be prepared for certain types of emergencies. The rule was not rewritten so as to exempt facilities which provide only counseling.

N.J.A.C. 8:43A-3.6(b)

COMMENT: National Medical Care, Inc., requested that the rule differentiate nonprofit institutions from proprietary institutions, since policies and procedures of the latter type of institution are proprietary and confidential.

RESPONSE: The policies and procedures which comprise the manual described at N.J.A.C. 8:43A-3.6(a) are the policies and procedures to which patients, staff, and the public should have access. Areas addressed include the program's treatment philosophy, quality assurance program, hours of operation, and maintenance of personnel records. There is no basis in either policy or law for affording proprietary agencies preferential status by exempting them from compliance with this standard. The rule was not rewritten.

N.J.A.C. 8:43A-3.7(a)

COMMENT: Solomon Goldberg, D.D.S., noted that whereas the first sentence refers to "employees," the second refers to "other persons providing direct patient care" and questioned whether the latter is intended to refer to non-employees such as volunteers and independent contractors.

RESPONSE: Although the phrase "other persons providing direct patient care" does refer to non-employees, the rule does not necessarily require a physical examination of such persons. The rule directs the facility to deterine the circumstances under which such persons will receive a physical examination.

N.J.A.C. 8:43A-3.8(a)1

COMMENT: A number of family planning facilities and organizations questioned whether or not it was the intent of the proposed rule to apply to events such as inservice training, celebrations, and events affecting the entire community, such as power outages, since these events could result in facility closure for six or more hours. The meaning of "unanticipated" was also questioned.

RESPONSE: The term "unanticipated events" is intended to refer to events which are not scheduled. Scheduled events do not need to be reported. The rule does require that events such as power outages resulting in closure for six or more hours be reported.

N.J.A.C. 8:43A-3.8(a)3

COMMENT: Four family planning facilities and organizations commented that the rule is too broad and should be limited to notification in the event of the occurrence of "reportable diseases."

RESPONSE: The rule was not rewritten. The Department regularly includes this rule in licensure manuals of health care facilities. Inclusion

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of this rule supports the Department's effort to eliminate public health hazards by facilitating investigation of the causes of epidemic disease.

N.J.A.C. 8:43A-3.8(a)4

COMMENT: Clarification of the rule was requested by a number of family planning facilities and organizations. The letters expressed uncertainty as to whether or not certain events constitute crimes. The meaning of "life or safety of patients or staff" was questioned as was the use to which the Department would put the reported information.

RESPONSE: The rule attempts to limit the reportable crimes to only those which also endanger life or safety and which have actually been reported to the local police. If it is not the case that all of these conditions are satisfied, then the crime need not be reported to the Department. Although the facility will need to make judgements as to whether or not a crime has been committed and the extent to which a crime jeopardizes life or safety, it is not clear that further definition would facilitate this activity.

The use to which the reported information could be put by the Department would depend on the nature of the information. For example, it could lead the Department to investigate whether or not facility security practices were sufficient to protect the health and safety of patients. In other cases, prior notice concerning an event which may receive state or local press coverage or investigation by criminal justice authorities is desired.

N.J.A.C. 8:43A-3.8(c)

COMMENT: It was suggested that, since family planning agencies funded by the Department already report resignation or termination of the administrator to the funding source, such facilities should be exempt from the rule. Newark Beth Israel Medical Center stated that the reported information would not be meaningful.

RESPONSE: The Department maintains that it is necessary that this information be forwarded to the Division of Health Facilities Evaluation and Licensing of the Department. If this information is submitted to a funding source within the Department, it would suffice to forward to the aforementioned division a copy of the submission to the funding source. The rule was not rewritten.

N.J.A.C. 8:43A-3.9(a)2

COMMENT: Newark Beth Israel Medical Center stated that the posting of licensure deficiencies would benefit neither patients nor the community. A notice of availability of the information in the business office would be more appropriate. Deficiencies under review or litigation may not reflect actual facility status.

RESPONSE: The rule does not require the posting of deficiencies. As the commenter recommended, the rule requires the posting of a notice that the list of deficiencies "is available in the facility during business hours to patients and the public." No change to the rule was required.

N.J.A.C. 8:43A-4.1(a)

COMMENT: It was noted by Newark Beth Israel Medical Center that the board of directors of a medical center serves as governing authority for an ambulatory care facility in a hospital setting.

RESPONSE: The rule does not preclude the board of directors of a medical center from also functioning as the governing authority for an ambulatory care facility in a hospital setting.

N.J.A.C. 8:43A-4.1(a)4

COMMENT: Newark Beth Israel Medical Center stated that, for an ambulatory care facility in a hospital setting, the duties described by the rule are addressed in the medical center bylaws. Establishment of a parallel system would be "redundant and unnecessarily time-consuming."

RESPONSE: The rule does not specify where the duties of the governing authority are addressed; rather, the rule lists what the duties are. As long as these duties are performed by the governing authority, including a hospital board of directors serving as the governing authority for an ambulatory care facility in a hospital setting, the rule is satisfied. A "parallel system" is not required.

N.J.A.C. 8:43A-6.2

COMMENT: Newark Beth Israel Medical Center asserted that the "need to establish a Patient Care Policy Committee in a large teaching hospital setting would create another layer of administration and add little to patient care services." Since each outpatient service has a mechanism for coordinating care and directing administrative issues to the governing authority, addition of a policy committee would be wasteful and time-consuming, could affect continuity of care, and could be duplicative with respect to policies and procedures.

RESPONSE: The rule does not necessarily call for the creation of a new committee. If an existing entity already includes the prescribed staff and performs the prescribed functions, then the rule is satisified.

N.J.A.C. 8:43A-6.3(a)6

COMMENT: Representatives of Planned Parenthood of Monmouth County, Inc., stated that patients who receive outpatient surgical services at that facility are "young, healthy, medically low risk women whose risk of morbidity and mortality is small and comparable to outpatient procedures using local anesthetic and dental procedures." It was further claimed that patients who receive abortion services, which as one commenter indicated may involve conscious sedation, "have been counseled and informed of all risks that may potentially impact them during the procedure" and that implementation of this rule concerning advance directives would "present an undue burden on the patient's emotional well-being." Both the New Jersey Family Planning League, Inc., and the Family Planning Association of New Jersey maintained that the rule should not pertain in the case of individuals receiving conscious sedation, based on the low risk of the procedures and on the health status of the patients.

RESPONSE: The Department has attempted to identify those types of ambulatory care services for which an inquiry into the existence and location of an advance directive might be appropriate. The Department maintains that services involving anesthesia other than minor conduction block certainly deserve consideration in this regard, irrespective of the initial health status of the patient. Hence the rule requires the facility to consider the appropriateness of such an inquiry and to specify the circumstances underwhich it will be made. In any case, provision of the written statement of the patient's right regarding an advance directive required by N.J.A.C. 8:43A-6.3(a)6ii should not "present an undue burden." The rule was not rewritten in the manner requested.

COMMENT: Newark Beth Israel Medical Center observed that since a hospital outpatient clinic is functionally part of a larger entity, "requiring advance directives assistance at the surgical clinics," for example, could be "duplicative of an already centralized function."

RESPONSE: The rule does not specify the location at which the assistance required by the rule is to be provided. Duplication of a centralized function is not required.

N.J.A.C. 8:43A-6.6

COMMENT: Newark Beth Israel Medical Center stated that it would be too expensive to "maintain employees specifically for translating," given a diverse patient population. Interpretation should be provided on a "backup basis." Newark Beth Israel Medical Center currently maintains an active list of employees who are bilingual.

RESPONSE: The rule requires that interpretation services be provided "when necessary." This may be consistent with the commenter's suggested practice of providing interpretation on a "backup basis," if such a practice is sufficiently effective to meet the intent of the rule.

N.J.A.C. 8:43A-6.8(b)

COMMENT: Two hospitals, Newark Beth Israel Medical Center and the Valley Hospital, commented on this rule on financial arrangements. The former noted that charges for services provided on an ad hoc basis cannot be communicated to patients in the same way as charges for "known or elective services that are prescheduled." Some charges, such as those based on time, are not determined until after the service has been provided. It was argued that compliance with the rule would be "extremely time consuming and wasteful." The Valley Hospital added that the rule should not apply to hospitals because they are already regulated with respect to pricing.

RESPONSE: The rule does not assume that the total cost of services can be known beforehand. In fact, N.J.A.C. 8:43A-6.8(d) allows for the possibility of charges, expenses, and other financial liabilities in excess of the predetermined rate. Rather, the rule requires that there exist a predetermined fee schedule from which an estimate can be made, given the expectations regarding services to be provided. The Department maintains that the rule would provide useful information to patients, including hospital outpatients, and, thus, would not be "wasteful." The rule was not rewritten in the manner suggested.

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N.J.A.C. 8:43A-7.2

COMMENT: Newark Beth Israel Medical Center indicated that, contrary to the structure implied by the proposed rule, directors of individual departments in a hospital "are responsible for the provision of outpatient services in their area of expertise."

RESPONSE: Designation of a medical director within each service would represent an acceptable means of satisfying the rule. Alternatively, the medical director of the hospital could be designated medical director of ambulatory care services. This mechanism will be reflected in the new rules for hospital outpatient services to be proposed as an addition to the Hospital Licensing Standards, N.J.A.C. 8:43G.

N.J.A.C. 8:43A-7.4

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey maintained that, if the facility is limited to the provision of CT, MRI, or radiological services, certain provisions of the rule, such as the one regarding medical staff bylaws, should not apply. Such facilities typically have a medical staff of four or fewer radiologists.

RESPONSE: The Department does not agree that the need for medical staff bylaws and the other elements of the rule is contingent on the medical staff exceeding a specified critical size. The particular form of the policies, such as the plan for medical staff meetings, however, may vary systematically with the number of medical staff members. Such variation is not in conflict with the rule. The rule was not rewritten in the manner suggested.

N.J.A.C. 8:43A-8

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey stated that the rule should apply to freestanding diagnostic centers only when necessitated by physician order, since such facilities do not otherwise have need of nursing services.

RESPONSE: N.J.A.C. 8:43A-25.1(a)3 exempts facilities which provide only MRI services from the requirement at N.J.A.C. 8:43A-3.1(a) for nursing services to be provided in the facility. N.J.A.C. 8:43A-25.1(a)3 was rewritten, however, so as to extend to other categories of strictly diagnostic facilities and to nullify the exemption in cases in which nursing services are required by physician order.

N.J.A.C. 8:43A-9.1

COMMENT: Both the New Jersey Academy of Consultant Pharmacists and the Joint Board for Certification of Consultant Pharmacists noted that proposed N.J.A.C. 8:43A-9.1 addresses institutional pharmacies only. The latter commenter recommended that a certified consultant pharmacist be designated in the absence of an institutional pharmacy and that the facility "provide pharmaceutical services, either directly or by contract with a provider pharmacy, in compliance with N.J.A.C. 13:39." The New Jersey Academy of Consultant Pharmacists stated that the proposed standards do not address pharmaceutical services in cases in which there is no institutional pharmacy and, therefore, a number of questions regarding issues such as dispensing and accountability remain. It was recommended that such facilities obtain drugs through contract with outside providers and that a certified consultant pharmacist be retained to develop and implement appropriate policies and procedures. The consultant would review patient charts and visit the facility monthly to monitor services and compliance with policies. The commenter stated that use of the consultant pharmacist has been of value to nursing facilities.

RESPONSE: Although N.J.A.C. 8:43A-9.1 refers only to facilities having institutional pharmacies, the remainder of the subchapter does treat all ambulatory care facilities "regardless of whether or not the facility has an institutional pharmacy" (see N.J.A.C. 8:43A-9.2). These other rules, particularly those at N.J.A.C. 8:43A-9.3 on policies and procedures, address concerns of the commenters. For example, dispensing and accountability are addressed at N.J.A.C. 8:43A-9.3(b)3, 5, 6, 7 and 8, at N.J.A.C. 8:43A-9.4(b), and at N.J.A.C. 8:43A-9.5(e). The requirement for the provision of pharmaceutical services directly or through written agreement is at N.J.A.C. 8:43A-3.1(a), and compliance with the Board of Pharmacy rules, N.J.A.C. 13:39, is required at N.J.A.C. 8:43A-9.3(b)5.

The Department maintains that there are two cases which warrant a requirement for a consultant pharmacist at this time—an ambulatory surgical facility which does not have an institutional pharmacy and a methadone facility which does not have an institutional pharmacy. These requirements for consultant pharmacists are at N.J.A.C. 8:43A-12.16 and N.J.A.C. 8:43A-26.6, respectively. No such general requirement has been added at N.J.A.C. 8:43A-9.

N.J.A.C. 8:43A-9.1(b)

COMMENT: The Joint Board for Certification of Consultant Pharmacists suggested additions to the responsibilities listed for the director of pharmaceutical services. These included monthly inspection of all areas in which medications are dispensed, administered, or stored, proposing solutions to problems observed, and monitoring of patient drug therapy for at least unnecessary drugs, medication errors, and adverse drug reactions. The New Jersey Pharmaceutical Association recommended that the designated pharmacist be the "pharmacist-in-charge" required by the New Jersey State Board of Pharmacy Rules and that this pharmacist be responsible "for the security of all pharmaceuticals in the pharmacy" and be required "to assist in security for all pharmaceuticals in the facility." This commenter suggested adding area inspection and patient drug therapy monitoring to the list of policies and procedures addressed at N.J.A.C. 8:43A-9.3(b).

RESPONSE: The rule requires that the designated pharmacist be responsible for the direction, provision, and quality of pharmaceutical services. It could be expected that these duties would necessitate periodic inspection of the facility, proposal of solutions to problems, and monitoring of patient drug therapy and would include responsibility for drug security both in the pharmacy and in the remainder of the facility. N.J.A.C. 8:43A-9 is written with the purpose of ensuring quality by assigning this level of responsibility to the designated pharmacist and then specifying at N.J.A.C. 8:43A-9.3(b) the areas to be addressed by the facility's policies and procedures, such as reviewing adverse drug reactions and medication errors. Given this strategy, no further duties have been explicitly added at N.J.A.C. 8:43A-9.1(b). Finally, it would be beyond the scope of the rules to identify the "pharmacist-in-charge" required by the Board of Pharmacy Rules with the pharmacist designated in accordance with N.J.A.C. 8:43A-9.1(b).

N.J.A.C. 8:43A-9.2

COMMENT: The New Jersey Pharmaceutical Association recommended the addition of a sentence to the rule stating that "pharmacists in charge of an institutional pharmacy or the consultant pharmacist of the facility where no institutional pharmacy exists shall hold current certification by the Joint Board of Certification of Consultant Pharmacists."

RESPONSE: The Department acknowledges that certification by the Joint Board of Certification of Consultant Pharmacists would be indicative of attainment of a higher level of skill, but does not believe that certification is essential for fulfilling the responsibilities delineated in the proposed rules. In fact, the licensure standards for long-term care facilities at N.J.A.C. 8:39 do not require such certification. The rule was not rewritten in the manner suggested.

N.J.A.C. 8:43A-9.3(a)

COMMENT: The New Jersey Pharmaceutical Association indicated this rule as the appropriate place to add a requirement for a consultant pharmacist to visit the facility quarterly, to work with provider pharmacies, and to assist with the items listed in the rule. The commenter cited by way of justification the experience with consultants in long-term care facilities and the Federal standards for "other facilities not dissimilar from the facilities covered by these regulations." The respondent also recommended the addition here of a requirement for the facility to provide services directly or by contract with a licensed pharmacy.

RESPONSE: As discussed above in reference to comments on N.J.A.C. 8:43A-9.1, no general requirement for a consultant pharmacist is being added at this time.

Proposed N.J.A.C. 8:43A-9.3(b)5 was revised so as to require that pharmaceutical services provided by written agreement be provided by a pharmacy licensed by the New Jersey State Board of Pharmacy, though individual patients may choose to obtain medications from out-of-State pharmacies.

N.J.A.C. 8:43A-9.4(b)

COMMENT: Both the Joint Board for Certification of Consultant Pharmacists and the New Jersey Pharmaceutical Association recommended that "dispensed" be replaced by "administered."

RESPONSE: The rule was intended to address both dispensing and administration and, hence, was not rewritten.

N.J.A.C. 8:43A-10

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey recommended that this section not apply to

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freestanding diagnostic services limited to CT, MRI, or radiological services.

RESPONSE: The Department believes that exempting strictly diagnostic facilities from N.J.A.C. 8:43A-10.1 would not jeopardize patient health or safety. Consequently, the exemptions listed at N.J.A.C. 8:43A-25.1(a)1 through 6 for such facilities have been expanded to include exemption from that part of N.J.A.C. 8:43A-3.1(a) which requires counseling services to be provided directly by the facility or through written agreement.

N.J.A.C. 8:43A-12.1(b)

COMMENT: South Jersey Urologic Associates suggested that the rule be revised so as to allow surgical facilities to accept a patient on the condition that the patient will be discharged within a 24-hour period. It was claimed that this would be cost-effective and consistent with the goal of promoting high quality care.

RESPONSE: The Department believes that the term "overnight care" in the current rule is insufficiently precise. Having reconsidered the function of the rule, the Department has rewritten the rule so as to replace "overnight care" with reference to the 24-hour time period suggested by the commenter.

N.J.A.C. 8:43A-12.3(c)

COMMENT: The Family Planning Association of New Jersey and the New Jersey Family Planning League, Inc., expressed concern about the board certification requirement for the director of anesthesia services of facilities using conscious sedation. It was stated that the use of conscious sedation is "within the scope of practice of surgeons and obstetrician/gynecologists." Three representatives of Planned Parenthood of Monmouth County, Inc., maintained that exemption of facilities using only conscious sedation from this rule would remove a burden and a source of administrative duplication without affecting patient care or safety. Planned Parenthood of Greater Northern New Jersey, Inc., and Planned Parenthood of Passaic County, Inc., added that both this rule and N.J.A.C. 8:43A-12.3(d) are unnecessary in the case of conscious sedation.

RESPONSE: In response to the commenters' concern, a new provision was added at N.J.A.C. 8:43A-12.3(c)1. The Department is willing to permit facilities using only conscious sedation to not appoint a board-certified anesthesiologist as director of anesthesia services on the condition that each of the physicians who administer, supervise, or monitor conscious sedation in the facility is credentialed by an acute care hospital, licensed in New Jersey in accordance with N.J.A.C. 8:43G, to administer, supervise, and monitor conscious sedation. The Department maintains that this condition is necessary in order to protect the health and safety of patients receiving that level of anesthesia.

N.J.A.C. 8:43A-12.3(i)

COMMENT: A number of respondents recommended that the rule allow registered nurses to administer medications for conscious sedation under direct physician supervision. The New Jersey Family Planning League, Inc., submitted a position statement supporting this role of the registered nurse which has been endorsed by 21 national nursing organizations. Representatives of Planned Parenthood of Monmouth County, Inc., noted that the revised rule together with the definition of "conscious sedation" would then allow the registered nurse to administer oral as well as parenteral medication.

The Radiological Society of New Jersey and MRI of Northern New Jersey added that "it is not unusual for some patients who are about to undergo a MRI procedure to be administered medication to relieve the patient of any anxiety which may be associated with the procedure." Nurses are trained to administer conscious sedation and should be permitted to do so. Moreover, if staff are adequately trained, there should not be a requirement for the presence of a physician.

RESPONSE: The Department does not permit the recommended practice of having a registered nurse administer medications for conscious sedation in hospitals and maintains that it would be equally inappropriate in ambulatory care facilities. On February 24, 1992, the Department issued interpretive guidelines for the administration, supervision, and monitoring of conscious sedation as Advisory Bulletin A-1-92. In that communication, N.J.A.C. 8:43A-12.3(i) was interpreted as it applies to procedures in which supplemental doses of anesthetic agents used for conscious sedation are given following administration of the initial dose. The current wording and intent of the rule, together with the February 1992 interpretation regarding supplemental doses, are being retained without change at this time.

N.J.A.C. 8:43A-12.16

COMMENT: Planned Parenthood of Greater Northern New Jersey, Inc., stated that the rule "is redundant, given the policies and procedures that agencies already have in place." It was noted that a single drug may be used for conscious sedation and that formularies and protocols are presently reviewed by medical directors, community-based medical committees, and Department of Health evaluators. Three representatives of Planned Parenthood of Monmouth County, Inc., maintained that exemption of facilities using only conscious sedation from this rule would remove a burden and a source of administrative duplication without affecting patient care or safety.

RESPONSE: The Department does not agree that exemption of facilities using only conscious sedation from this rule would not affect patient care or safety. The Department maintains that semiannual review of facility policies and procedures by a consultant pharmacist independent of the provider pharmacy represents a cost-effective means of enhancing quality of pharmaceutical services in the absence of an institutional pharmacy for facilities in which anesthetic drugs are stored. The rule was not rewritten in the manner requested.

N.J.A.C. 8:43A-12.18

COMMENT: A number of family planning facilities and organizations expressed agreement with the manner in which the proposed rule generally exempts facilities in which local anesthesia or minor conduction blocks only are administered from the rules in N.J.A.C. 8:43A-12 while specifying those rules which do apply. The commenters recommended that a similar revision be adopted with respect to facilities using conscious sedation so as to better reflect the actual risks associated with this level of anesthesia. Lists of citations of rules which would be appropriate to conscious sedation were suggested by the commenters. Each list had the following recommended rules in common: N.J.A.C. 8:43A-12.1, 12.2, 12.3(a), (e), (g), (i), (k), (l), and (n), 12.4, 12.5, 12.6(a)1 through 3, 5, 8, and 9, 12.9(d), (f), and (g), 12.10, 12.12(b), (c), and (d), and 12.17. Several of the lists submitted also included N.J.A.C. 8:43A-12.11. Planned Parenthood of Monmouth County, Inc., added that this exemption "would also change the post anesthesia care unit and staffing requirements to be more appropriate for patients who only receive conscious sedation and who are ambulatory prior to being admitted to the post anesthesia care unit."

RESPONSE: The Department has again reviewed the rules in N.J.A.C. 8:43A-12 with the purpose of examining their applicability to facilities in which conscious sedation only is employed. It has been determined that the proposed rules, as amended in this notice of adoption, are commensurate with the risks presented by the use of conscious sedation. Where a rule more appropriately addresses general anesthesia, such as N.J.A.C. 8:43A-12.3(f) and N.J.A.C. 8:43A-12.9(e), the rule already excludes conscious sedation. Consequently, no general exemption was added.

N.J.A.C. 8:43A-13.1(c)

COMMENT: Comments on this rule emanted from diverse segments of the ambulatory care industry. The Radiological Society of New Jersey and MRI of Northern New Jersey recommended that the rule be revised to allow the common practice by which diagnostic films are forwarded to the referring physician following the diagnostic study.

Comments from family planning facilities and organizations included the observation that medical records are routinely transported between clinic satellites and the main site. Clarification of the rule as it pertains to such transfer and to off-site storage of inactive records was requested. It was stated that one-hour retrieval is unnecessary for records which could be as old as 20 years and that family planning facilities should either be exempt from the rule or subject to a 72-hour retrieval time limit.

Newark Beth Israel Medical Center claimed that, since medical record availability is in the interest of the facility and the patient, Departmental approval of off-site storage is unnecessary. Liability remains with the facility, and the rule is intrusive. The one-hour retrieval time would only be "meaningful" in emergency situations, and then as an optimum standard. Twenty-four hours would be more appropriate for scheduled cases.

National Medical Care, Inc., indicated that, due to their limited hours of operation, freestanding dialysis facilities "will not be called upon to retrieve medical records in the middle of the night or on a Sunday." Consequently, the rule should recognize this distinction between them and hospital dialysis units.

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RESPONSE: The rule is not intended to prohibit the forwarding of diagnostic films to referring physicians. Although N.J.A.C. 8:43A-13.3(a)4 requires that the medical record include results of diagnostic tests, these results need not take the form of the original films. In any event, the facility must comply with the State statute on retention of medical records, N.J.S.A. 26:8-5 et seq.

Transfer of medical records between satellites and affiliated facilities is permitted (see N.J.A.C. 8:43A-27.5(a)). The Department has determined that off-site storage may be used without prior approval of the Department provided that the Department is given prior notice, including the details of the storage arrangement. Both N.J.A.C. 8:43A-13.1(c) and 27.5(a) were rewritten so as to permit this practice. Also, the retrieval time for records stored off-site has been changed to a more achievable "one business day."

N.J.A.C. 8:43A-13.5(b)

COMMENT: Newark Beth Israel Medical Center maintained that "establishment of a fee for copying medical records should be within the purview of the ambulatory care facility and not the Department of Health" and that the "fees should be based upon normally accepted standards established by Medicare and other Federal agencies."

RESPONSE: The Department has concluded, based on experience with consumer complaints, that it is necessary to place an upper limit on the charges which may be assessed for copies of medical records. The fee schedule which was proposed was derived from that specified in the hospital licensing standards at N.J.A.C. 8:43G-15.3(d). Since this schedule has been tested in practice, and since no specific criticism of the actual fees was offered, the rule was not rewritten as requested.

N.J.A.C. 8:43A-13.5(c)

COMMENT: The reevaluation of the fee schedule for medical records was addressed by Newark Beth Israel Medical Center. It was claimed that the rule is inadequate as proposed. The rule should specify the review period and methodology for determining changes in the fee schedule and should take into account current cost of living.

RESPONSE: The rule was revised so as to indicate that the periodic reevaluation would be followed by formal proposal of an amendment if a change to the fee schedule were warranted. Such a proposal would necessarily provide justification for the amendment and discuss its impact on providers and patients.

N.J.A.C. 8:43A-14.2

COMMENT: Newark Beth Israel Medical Center noted that hospital outpatient departments may presently follow the policies and procedures of the hospitals' infectious disease committees. Consequently, the proposed rule would result in duplication and use of additional staff and would not be cost-effective.

RESPONSE: It is not necessarily the case that compliance with the rule would require additional staff doing duplicative work. If the hospital's policies and procedures are developed, implemented, and reviewed by a committee including at least the persons specified at subsection (a) and address at least the areas enumerated at subsection (b), then a separate committee is not required. The rule, therefore, was not rewritten.

N.J.A.C. 8:43A-14.5(c) and (d)

COMMENT: A number of family planning facilities and organizations stated that the two rules go too far in requiring documentation of sterilization loads. The New Jersey Family Planning League, Inc., asserted that the recording of certain values exceeds normal quality control procedures for items which are being disinfected by steam sterilization, but which will not be maintained in a sterile environment. An exemption for such items was requested. It was asked whether or not "sterilization load" was intended to refer only to those instruments to be maintained in a sterile environment. Since indicator tapes are routinely used, the purpose of recording load content was questioned. Planned Parenthood of Monmouth County, Inc., stated that the requirements would be "extremely burdensome" and noted that, since, for example, individual packages are marked with expiration dates, additional documentation would do nothing to "increase patient safety or insure quality control."

RESPONSE: The term "sterilization load" is intended to refer to instances in which the apparatus is used to "sterilize" the contents. "Sterilization" is defined at N.J.A.C. 8:43A-1.3. The two rules in question do not apply to cases of high-level disinfection. The Department recognizes the distinction between the processes of sterilization and disinfection and the results which they are intended to ensure. Given this interpretation, no exemption is required.

The Department maintains that documentation of load content is important. Indicator tapes do not show whether or not the sterilizer attained the proper temperature for an adequate amount of time, and results of biological monitoring of steam sterilizers require some time to be read. If the results indicate a need for a recall, then reference will have to be made to documentation of load content. Since N.J.A.C. 8:43A-14.4(f) and (g) require that sterilized materials be marked with the expiration date, however, the record of each sterilization load need not include the expiration dates of the contents, and N.J.A.C. 8:43A-14.5(d) was rewritten accordingly.

N.J.A.C. 8:43A-15.2(a)

COMMENT: Newark Beth Israel Medical Center stated that the requirement for quarterly drills on each shift would be excessive, since the patients are ambulatory and the Joint Commission on Accreditation of Healthcare Organizations requires two drills per year. Quarterly fire drills, including at least two simulated evacuations, would be sufficient. The hospital licensing standards also contain drill requirements.

RESPONSE: The Department maintains that the total number of required drills must take the number of shifts into account and that drills must anticipate events other than fire. Consequently, the rule was not rewritten in the manner suggested. Moreover, it is not clear that the ambulatory nature of the patients should permit a reduction in the number of minimally required drills. If the hospital-wide drills which are conducted meet the requirements of N.J.A.C. 8:43A-15.2(a), however, then they would count towards the required total number of drills.

N.J.A.C. 8:43A-17.3(a)12 and 13

COMMENT: Planned Parenthood of Monmouth County, Inc., suggested that the acceptable temperature range be changed from 72 to 82 degrees to 68 and 86 degrees Fahrenheit due to the range of attire worn by ambulatory patients in the facility. Two other respondents recommended a range of 68 to 90 degrees. One commenter stated that the systems necessary to maintain the proposed range would be too costly.

RESPONSE: The rule was not rewritten. The suggested ranges would not be consistent with the provisions of the State statute concerning heat emergencies which, although not written specifically for ambulatory care facilities, was given consideration in the development of this rule and sets the maximum temperature at 82 degrees Fahrenheit.

N.J.A.C. 8:43A-17.3(b)7

COMMENT: National Medical Care, Inc., maintained that the proposed rule would require "the construction or rental of off site storage areas to maintain substances and materials which are routinely used . . . ." Expense and inconvenience would follow. The commenter recommended that the rule allow for the storage of the substances in limited amounts and for limited periods of time.

RESPONSE: Since the rule as proposed allows for the storage of "minimum supplies" of paints, varnishes, lacquers, thinners, and other flammable materials in the facility, construction or rental of off-site storage areas should not be necessary. The rule does not limit the duration of storage. The rule was not rewritten.

N.J.A.C. 8:43A-19.4

COMMENT: The New Jersey Family Planning League, Inc., asserted that the rule would have a "tremendous economic impact." Any construction project would require Departmental approval. Clarification was requested regarding the identity of the construction official cited in subsection (c) and of the party who would determine the value of the structure. Reference to any appropriate state statute was requested, as was identification of an appeal process. It was recommended that subsection (c) be deleted. Planned Parenthood of Monmouth County, Inc., added that "facility alterations are subject to local building codes and inspections" and that the rule would "unnecessarily delay and increase the cost of minor changes." The effect on patient care was questioned. This commenter suggested that, at least, rooms other than surgical procedure rooms be exempt.

RESPONSE: The State Uniform Construction Code Act, P.L. 1975, c.217, as amended, governs all construction in New Jersey and underlies the Uniform Construction Code. N.J.A.C. 8:43A-19.4 was derived directly from N.J.A.C. 5:23-2.4(a) of the Uniform Construction Code Regulations

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and, hence, no exemptions can be written into N.J.A.C. 8:43A-19.4. The construction officials identified at N.J.A.C. 8:43A-19.4(c) are municipal construction officials.

N.J.A.C. 8:43A-21.1, 22.1 and 28.3(a)

COMMENT: The Southern New Jersey Cooperative recommended that membership in the regional maternal and child health consortium be required of licensed facilities providing family planning, prenatal, postpartum, and pediatric services and of licensed birth centers. State rules require consortia governing boards to be representative of both hospital and non-hospital providers and consumers. It was stated that "participation in the consortium would assure that ambulatory services are coordinated within the system of care, that consumers of the services at those sites have access to other regional health care resources, and that these organizations will be contributing to the development of the regional prevention plan."

RESPONSE: The Department agrees with the commenter's recommendation regarding the importance of membership in the regional maternal and child health consortium and has added a requirement for such membership at N.J.A.C. 8:43A-21.1 and at N.J.A.C. 8:43A-22.1. It should be noted that N.J.A.C. 8:33C-2.1 requires that the regional maternal and child health consortium include as general members all licensed ambulatory care facilities which provide prenatal care and care to infants and families with children up to age 18.

The corresponding requirement for birth centers is already included at N.J.A.C. 8:43A-28.3(a).

N.J.A.C. 8:43A-21.5(a)

COMMENT: The Southern New Jersey Perinatal Cooperative stated that this rule regarding the content of the medical record for prenatal patients should include "the essential elements of prenatal and postpartum care such as health education, psychosocial assessment and counseling, nutrition assessment, and referral for home follow-up services as necessary." It was recommended that the provisions of proposed N.J.A.C. 8:43A-28.8, which addresses additional patient care services for patients in birth centers, be added to this rule also. These provisions include requirements for laboratory tests and diagnostic procedures.

RESPONSE: The Department agrees that the medical record should be comprehensive and should include the essential elements of care. In fact, the Department prescribes the content of a comprehensive perinatal record at N.J.A.C. 8:33C-4.3(a). In response to the commenter's suggestion, reference to this comprehensive perinatal record has been added at both N.J.A.C. 8:43A-21.5(a) and 28.8(f).

N.J.A.C. 8:43A-22.3

COMMENT: The Southern New Jersey Perinatal Cooperative recommended the addition of documentation of nutrition counseling and injury prevention education to the pediatric medical record requirement.

RESPONSE: The Department acknowledges the value of nutrition counseling and injury prevention education for pediatric patients. Requirements concerning the availability of dietary counseling and health education may be found at N.J.A.C. 8:43A-10.1(a) and 6.3(a)16, respectively. N.J.A.C. 8:43A-22.3, which specifically addresses the medical record, was not rewritten.

N.J.A.C. 8:43A-23

COMMENT: The New Jersey State Department of Human Services expressed concern regarding requirements for "limited purpose primary care facilities and satellite facilities." The commenter noted that the Department of Human Services has been working with the Department of Health "to establish a health centers category that provides primary and preventive care in community, Head Start, and school settings." Although the facilities in the envisioned category would need a simple examination room and access to a sink rather than more extensive physical features such as major air handling systems, this proposed subchapter incorporates by reference guidelines more appropriate for larger facilities, that is, Sections 9.1 and 9.2 of the Guidelines for Construction and Equipment of Hospital and Medical Facilities (see N.J.A.C. 8:43A-23.5(b)). The proposed rules do not "provide the flexibility needed to get services to low income clients at non-traditional locations." They also impede billing and acquisition of federal funds. The commenter, consequently, recommended the establishment of a new licensure category entitled "community and school health centers (limited use)."

RESPONSE: Although the Department is not establishing a new licensure category at this time, the facilities described by the commenter may be accommodated within the structure defined by these rules. They might be considered, for example, as primary care facilities or satellite facilities.

An attempt was made in the proposed rules to recognize the different physical plant needs of smaller facilities. In order to clarify the intent that small ambulatory care facilities, including small primary care facilities, not be required to meet the same physical plant standards as general outpatient facilities, N.J.A.C. 8:43A-19.6, 23.4, and 23.5(b) were rewritten. The rewritten rules specify that the smaller facilities must comply with section 9.4 of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, but not with sections 9.1, 9.2, or 9.3. Additional waivers will be considered on an individual basis.

N.J.A.C. 8:43A-23.3

COMMENT: Solomon Goldberg, D.D.S., raised the question as to the criteria which the Department would use in approving use of mobile vans. He also questioned the mechanism for ensuring patient safety and asked whether or not the vans would be separately licensed.

RESPONSE: The determination of which rules at N.J.A.C. 8:43A would actually be applied to the mobile van would be contingent upon the types of services which the van would be utilized to support. In the interest of patient safety, N.J.A.C. 8:43A-23.3(b) lists the areas to be addressed through policies and procedures. Vans would not be separately licensed.

N.J.A.C. 8:43A-24.2(a)

COMMENT: National Medical Care, Inc., commented on that part of the rule which limits an open dialysis treatment area to 20 stations. It was stated that that number is exceeded in several existing facilities. The rule could, consequently, necessitate reconstruction, temporary cessation of operation, and patient transfer. This provision of the rule should be applied only to new facilities.

RESPONSE: On the basis of the commenter's statement, the rule was rerwritten so as to pertain only in the case of new construction or renovation involving at least 25 percent of the physical plant.

N.J.A.C. 8:43A-24.5

COMMENT: National Medical Care, Inc., stated that the proposed section "does not recognize the nursing resource constraints caused by the nursing shortage in New Jersey" and "does not reflect the extent to which patient care technicians, operating under the direct supervision of R.N.s, are successfully utilized."

RESPONSE: The Department maintains that the required minimum nurse staffing ratios, as adopted, will not require a substantial increase in the number of nurses employed by facilities. In addition, the rules do recognize the value of trained technicians and explicitly refer to this level of personnel in the specification at N.J.A.C. 8:43A-24.5(a) of the general minimum staffing ratio for chronic dialysis services.

N.J.A.C. 8:43A-24.5(a)

COMMENT: According to National Medical Care, Inc., a number of inequities would follow when the 1:9 registered nurse to patient ratio is applied to facilities with different numbers of stations. The example of the 20-station unit versus the 10-station unit was used to illustrate the point. The commenter recommended that the rule apply as written to facilities with fewer than 18 stations, but that facilities with more than 18 stations be required instead to have at least two registered nurses. It was noted that larger facilities routinely employ a head nurse for each shift and a director of nursing services who are not included in the ratio. Newark Beth Israel Medical Center observed that hospital-based units have more acutely ill patients in need of more nursing care than do ambulatory care facilities, yet the corresponding hospital rules are "less clear and require one RN." It was asserted that the rule places an "unwarranted, unfair burden on the Ambulatory Dialysis Unit." The commenter recommended that, if a ratio must be specified, it should be "determined by a standardized patient acuity/nursing care tool."

RESPONSE: The Department agrees that the general minimum nurse staffing ratio for ambulatory care facilities does not need to exceed that for hospital dialysis units. N.J.A.C. 8:43G-30.5(d) of the Hospital Licensing Standards requires that there be at least two registered nurses on duty whenever care is being provided to more than six patients. The proposed rule has therefore been rewritten so as to require at least one registered nurse for the first nine patients and an additional registered nurse if the patient population exceeds nine. As stated in the proposed rule, the director of nursing services may be included in meeting this

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requirement. The adopted rule is intended as a minimum standard, and the facility may choose to assign additional registered nurses to the unit on the basis of a patient acuity system.

N.J.A.C. 8:43A-24.6(g)

COMMENT: Newark Beth Israel Medical Center requested clarification of the rule as it pertains to disinfection of dialysis machines. The commenter stated that internal disinfection is unnecessary between each instance of patient use; external cleaning is sufficient. Internal disinfection should be performed in accordance with AAMI guidelines. Frequency of internal disinfection should depend on biological test results in relation to the current practices of the facility. Overdisinfection would increase replacement of parts due to corrosion.

RESPONSE: The rule was intended to address cleaning "and/or" disinfecting of patient reclining chairs, beds, mattresses, and dialysis machines. The rule was rewritten in the interest of clarity.

N.J.A.C. 8:43A-24.10(a)

COMMENT: Newark Beth Israel Medical Center stated that the handwashing sink requirement would "result in major inconveniences to patients." All patients would have to receive treatments elsewhere while the necessary plumbing work was being performed. It may not be possible to make such arrangements for all of the patients affected. Other groups have required practices which circumvent the issue by replacing the need for sinks with the need to use scrubs, mask, gloves, and gown. Based on the transfer of patients and cost to facilities involved, National Medical Care, Inc., recommended that the sink requirement apply only to new facilities.

RESPONSE: The Department maintains that handwashing sinks are necessary in the dialysis setting. Moreover, the Department believes that, for purposes of patient safety and infection control, the proposed ratio of handwashing sinks to dialysis stations is appropriate. Where significant financial hardship or physical impracticality precludes compliance, however, the Department will consider waiver requests submitted in accordance with N.J.A.C. 8:43A-2.9.

N.J.A.C. 8:43A-24.10(d) and (m)

COMMENT: National Medical Care, Inc., stated that some existing facilities will not be able to meet the floor area minimum requirements specified in the two rules without "extensive reconfiguration, reconstruction and perhaps even relocation." It was recommended that the rule be applied only to new facilities.

RESPONSE: As in the case of N.J.A.C. 8:43A-24.10(a) discussed above, the Department will consider waiver requests submitted in accordance with N.J.A.C. 8:43A-2.9 by existing facilities in which significant financial hardship or physical impracticality precludes compliance.

N.J.A.C. 8:43A-24.10(q)

COMMENT: Burlington County Dialysis Center interpreted the rule as requiring the "presence of a water fountain in the patient waiting area of the dialysis facility." This presence could be detrimental to the health of patients. Chronic dialysis patients "struggle" to limit fluid intake, as they are "constantly thirsty" yet usually "on a daily fluid restriction." Excess fluids are "medically contraindicated" and can have serious effects. It was recommended that dialysis facilities be exempt from the drinking fountain requirement.

RESPONSE: The intent of the rule is that a drinking fountain be "accessible" to all people in the waiting area, but not necessarily "present" in the waiting area. In the case of the chronic dialysis patients themselves, however, the facility would be expected to act in accordance with the patient's plan of care with respect to the patient's fluid intake. Given this intent, the rule was not rewritten.

N.J.A.C. 8:43A-25.1(a)2 through 5

COMMENT: These four rules grant exemptions to facilities which provide only magnetic resonance imaging services with respect to some of the more generic requirements in the chapter. The Radiological Society of New Jersey recommended that these exemptions be extended to facilities providing computerized tomography.

RESPONSE: On the basis of the revisions to N.J.A.C. 8:43A-25.1 discussed above in reference to comments on N.J.A.C. 8:43A-8, 10, and 3.1, the exceptions at N.J.A.C. 8:43A-25.1(a)2 through 5 have been extended to facilities providing only computerized tomography or radiological services.

N.J.A.C. 8:43A-25.2(a)

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey suggested that the term "available" be defined as it is in proposed N.J.A.C. 8:43A-25.2(b), that is, "capable of being reached."

RESPONSE: The definition of "available," as it pertains to personnel, is given at N.J.A.C. 8:43A-1.3 and reads "capable of being reached . . . unless otherwise defined." Thus, in the case of N.J.A.C. 8:43A-25.2(a), the definition suggested by the commenter applies and no change in the rule is required.

N.J.A.C. 8:43A-25.2(b)2

COMMENT: Neither the Radiological Society of New Jersey nor MRI of Northern New Jersey opposed the requirement of N.J.A.C. 8:43A-25.2(a)1 for a radiologist to be present in the facility whenever a contrast medium is being used during the course of a computerized tomography procedure. It was agreed that "a meaningful risk of adverse reaction exists to this contrast agent." The commenters, however, adduced evidence to the effect that the risk of severe reaction or death in the case of a contrast medium used during the course of a magnetic resonance imaging procedure is substantially less than in the corresponding computerized tomography case (for example, one death per 4000 years per MRI practice versus one death per 10 years per CT practice). Consequently, the commenters recommended that the requirement for the presence of a radiologist be replaced by a requirement for the presence of a registered nurse certified in advance life support by the American Heart Association.

RESPONSE: Although the documentation provided by the commenter in support of deleting the requirement for the presence of a radiologist in the case of MRI suggests a good safety record for one particular MRI contrast agent, the submitted evidence does not provide ample justification for differentiating the case of MRI in the manner requested. In fact, the product information submitted cautions that "diagnostic procedures that involve the use of contrast agents should be carried out under direction of a physician with the prerequisite training and a thorough knowledge of the procedure to be performed." The rule was not rewritten.

N.J.A.C. 8:43A-25.5(a)1

COMMENT: The Radiological Society of New Jersey maintained that the 250 square foot requirement is unnecessarily high. Given that the need for space is determined by apparatus size and that this size progressively diminishes as technology improves, the commenter stated that the rule should not specify a minimum area.

RESPONSE: It is not unusual for technological changes to necessitate amendments to licensure rules. If the 250 square foot requirement becomes unreasonable in the future, the Department would be willing and able to propose an appropriate amendment to the rule at that time. In the absence of any specific demonstration that the proposed rule is unreasonable under present circumstances, the rule was not rewritten.

N.J.A.C. 8:43A-25.5(a)4

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey commented that the rule "should permit off-site storage for inactive or unexposed film."

RESPONSE: The rule does not preclude off-site storage of inactive or unexposed film. Rather, the rule requires that the suite contain facilities for such storage and for the storage of active film.

N.J.A.C. 8:43A-25.5(a)11i and ii

COMMENT: The Radiological Society of New Jersey and MRI of Northern New Jersey recommened that the rules refer to "areas" rather than to "rooms" or "closets." The commenters added that soiled linen should be stored "separate and apart from clean linen."

RESPONSE: The rule as proposed is intended to ensure that soiled linen is stored apart from the clean linen supply. A facility may propose, through application for a waiver in accordance with N.J.A.C. 8:43A-2.9, to maintain such separation through the use of areas other than rooms or closets.

N.J.A.C. 8:43A-28.2(e)

COMMENT: Newark Beth Israel Medical Center noted that, while the provision of the rule which requires discharge or transfer within 24 hours is appropriate for most patients, there are occasions on which the patient is retained for a limited, additional time in order to "avoid

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discharge in the middle of the night or other hardships." The rule should allow for some flexibility while "maintaining the intent of a very limited stay."

RESPONSE: The Department recognizes that there may be circumstances in which it will be necessary to retain a mother and/or infant for a longer period of time. In such cases it is expected that the birth center would act in the interest of the patient. The rule was rewritten in such a way as to allow this flexibility, provided that the facility has previously documented that the mother and infant were expected to be discharged within 24 hours from the time of the infant's birth.

N.J.A.C. 8:43A-28.3(b)

COMMENT: While expressing approval of (1) restriction on use of the term "birth center," (2) restriction of surgical procedures and anesthesia, (3) the requirement to be designated as a "community perinatal center—birth center" which is part of a Maternal and Child Health Consortium, and (4) inclusion of a quality assurance program, the National Association of Childbearing Centers suggested a stronger "linkage" requirement. Not only should the birth center have an agreement with an affiliated community perinatal center, but, also, the affiliated community perinatal center should facilitate the establishment of a formal agreement with birth centers meeting all requirements of N.J.A.C. 8:43A-28.

The rule was not rewritten as suggested. The rules at N.J.A.C. 8:43A cannot include requirements for facilities other than ambulatory care facilities. Consequently, it would not be appropriate to attempt to regulate the activities of affiliated community perinatal centers, which are licensed hospitals and hence regulated by N.J.A.C. 8:43G, through these rules for ambulatory care facilities. The affiliation requested is mandated by these standards as well as by related perinatal planning regulations.

N.J.A.C. 8:43A-28.9(b)

COMMENT: The National Association of Childbearing Centers suggested that, rather than referring to "active labor," the rule refer to "second stages of labor, birth and immediate postpartum."

The intent of the rule is to ensure that two qualified staff members are present from the time "active labor" commences. The proposed wording, therefore, was retained without change.

N.J.A.C. 8:43A-29.2(b)

COMMENT: The Stone Center of New Jersey indicated that anesthesiologists cannot be certified by the groups specified in the rule. Consequently, reference to anesthesiologists should be deleted from the rule.

The Department accepts this information, and the rule was revised accordingly.

N.J.A.C. 8:43A-29.4(b)

COMMENT: The Stone Center of New Jersey requested verification that existing facilities would not need to comply with the requirements at N.J.A.C. 8:43A-29.4(a).

On the contrary, N.J.A.C. 8:43A-29.4(a) applies to "any facility which provides extracorporeal shock wave lithotripsy services." This rule incorporates by reference the relevant sections of the 1987 edition of the Guidelines for Construction and Equipment of Hospital and Medical Facilities and enumerates 14 additional requirements. N.J.A.C. 8:43A-29.4(b), in contrast, applies only to new facilities and exceeds (a) in that it both incorporates (a) and incorporates subsequent amendments and supplements to the 1987 edition of the Guidelines.

Summary of Agency-Initiated Changes:

At both N.J.A.C. 8:43A-1.5 and 12.3(c), the year "1972" was changed to "1982." It has come to the Department's attention that fellowships were actually granted through 1981.

N.J.A.C. 8:43A-2.2(c) and 2.5(b)1 were revised so that the applicant for licensure is obliged to request a preliminary conference, but the Department determines whether or not a conference is necessary in the case of that applicant.

A number of the proposed rules referred to the Guidelines for Construction and Equipment of Hospital and Medical Facilities, "1987 edition, as amended." This document was, in fact, amended recently. Consequently, N.J.A.C. 8:43A-12.17, 19.6, 19.7, 23.4, and 23.5(b) were revised so as to refer to the "1992-1993 edition, as amended."

The term "machine" was deleted from the term "machine/station" at N.J.A.C. 8:43A-24.2(a) and 24.10(a). The rules are intended to refer to the station, which includes more than the machine alone.

Proposed N.J.A.C. 8:43A-26.4(a)1iv and v were deleted and an exemption of N.J.A.C. 8:43A-8.1 was added to N.J.A.C. 8:43A-26.4(a)1 on the basis of information provided by the Division of Alcoholism, Drug Abuse and Addiction Services. The requirements at N.J.A.C. 8:43A-26.4(a)1i through iii, in conjunction with the requirement at N.J.A.C. 8:43A-7.2 for the availability of a medical director at all times, are sufficient to meet the objective of N.J.A.C. 8:43A-26.4(a)1.

Technical/editorial changes were made at the following citations: N.J.A.C. 8:43A-1.3 (definition of "medication"), 1.11(a)1, 1.27, 2.2(d), 3.6(a)7, 4.1(a)9, 12.14(j), 14.2(b)1, 19.1(a), 26.1(a), 27.5(a), 28.2(d), 28.6, 28.7(c), and 28.10(a)5.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 1. DEFINITIONS AND QUALIFICATIONS

8:43A-1.1 Scope

The rules in this chapter pertain to all health care facilities which provide ambulatory care services, including, but not limited to, primary care, hospital outpatient, ambulatory surgical, family practice, family planning, outpatient drug abuse treatment, chronic dialysis, *[outpatient physical therapy,]* computerized tomography, magnetic resonance imaging, extracorporeal shock wave lithotripsy, and radiological services. These rules also pertain to abortion facilities, ***comprehensive*** rehabilitation agencies, and birth centers. Ambulatory care facilities provide preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day. The rules in this chapter constitute the basis for the licensure of ambulatory care facilities by the New Jersey State Department of Health.

8:43A-1.2 Purpose

The goal of this chapter is to protect the health and safety of patients who receive ambulatory care services by establishing minimum rules and standards of care with which an ambulatory care facility must comply in order to be licensed to operate in New Jersey.

8:43A-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Advance directive" means a written statement of the patient's instructions and directions for health care in the event of future decision making incapacity. An advance directive may include a proxy directive or an instruction directive, or both.

"Affiliated community perinatal center" means a licensed hospital designated within a maternal and child health service region with which the birth center has a formal agreement for transfer and backup services. This hospital must be designated as either a community perinatal center—intermediate or intensive or a regional perinatal center, in accordance with N.J.A.C. 8:33C.

"Ambulatory care facility" means a health care facility or a distinct part of a health care facility which provides preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

"Available" means ready for immediate use (pertaining to equipment) or capable of being reached (pertaining to personnel), unless otherwise defined.

"Birth center" means a health care facility or a distinct part of a health care facility which provides routine prenatal and intrapartal care to low-risk maternity patients who are expected to deliver neonates of a weight greater than 2,499 grams and of 36 weeks gestational age and who require a stay of less than 24 hours after birth. "Routine intrapartal care" means labor and delivery services not requiring surgical intervention.

"Bylaws" means a set of rules adopted by the facility for governing its operation. A charter, articles of incorporation, or a statement of policies and objectives is an acceptable equivalent.

"Cardiac rehabilitation program" means a health care service in which an individualized program of physical exercise is prescribed for each cardiac patient.

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"Chronic dialysis" means dialysis rendered to a patient with end stage renal disease in whom recovery of renal function is not expected.

"Cleaning" means the removal by scrubbing and washing, as with hot water, soap or detergent, and vacuuming of infectious agents and of organic matter from surfaces on which and in which infectious agents may find conditions for surviving or multiplying.

"Clinical note" means a written, signed, and dated notation made by a health care professional who renders a service to the patient. Clinical notes are written into the patient's medical record the day service is rendered.

"Clinical practitioner" means a physician, dentist, podiatrist, certified nurse midwife, physician assistant, or nurse practitioner.

"Commissioner" means the New Jersey State Commissioner of Health.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Community perinatal center-birthing center" means a licensed birth center designated within a maternal and child health service region, in accordance with N.J.A.C. 8:33C.

"Comprehensive rehabilitation agency" means an ambulatory care facility which provides at least medical, physical therapy, and social or psychological services in a coordinated manner.

"Conspicuously posted" means placed at a location within the facility accessible to and seen by patients and the public.

"Contamination" means the presence of an infectious or toxic agent in the air, on a body surface, or on or in clothes, bedding, instruments, dressings, or other inanimate articles or substances, including water, milk, and food.

"Controlled Dangerous Substances Acts" means the Controlled Substances Act of 1970 (Title II, Public Law 91-513) and the New Jersey Controlled Dangerous Substances Act of 1970, N.J.S.A. 24:21-1 et seq.

"Counseling" means provision of information intended to direct the behavior of a patient. Counseling services include, but are not limited to, dietary counseling, social work, and/or drug counseling services.

"Current" means up-to-date, extending to the present time.

"Department" means the New Jersey State Department of Health.

"Disinfection" means the killing of infectious agents outside the body, or organisms transmitting such agents, by chemical and physical means, directly applied.

"Documented" means written, signed, and dated.

"Drug" means a substance as defined in the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39. The word "medication" is used interchangeably with the word "drug" in this chapter.

"Drug abuse treatment services" means methadone detoxification, methadone maintenance, and/or drug-free counseling programs.

"Drug administration" means a procedure in which a prescribed drug is given to a patient by an authorized person in accordance with all laws and rules governing such procedures. The complete procedure of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the prescriber's orders, giving the individual dose to the patient, seeing that the patient takes it (if oral), and recording the required information, including the method of administration.

"Epidemic" means the occurrence in a facility of one or more cases of an illness in excess of normal expectancy for that illness, derived from a common or propagated source.

"Family planning services" means comprehensive reproductive health care services including contraception, pregnancy detection, options counseling, diagnosis and/or treatment of sexually transmitted diseases, routine gynecological and cancer screening services, health promotion activites, and Level I infertility services. Family planning services may also include prenatal and postpartum care, other gynecological services including colposcopy and cryotherapy, menopausal services, and/or Level II and III infertility care. ***Family planning services do not include termination of pregnancy.***

"Full-time" means relating to a time period established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"Governing authority" means the organization, person, or persons designated to assume legal responsibility for the management, operation, and financial viability of the facility.

"Health care facility" means a facility so defined in N.J.S.A. 26:2H-1 et seq.

"Hospital" means a health care facility as defined in the Licensing Standards for Hospitals, N.J.A.C. 8:43G.

"Job description" means written specifications developed for each position in the facility, containing the qualifications, duties and responsibilities, and accountability required of employees in that position.

"Licensed nursing personnel" (licensed nurse) means registered professional nurses or practical nurses licensed by the New Jersey State Board of Nursing.

"Maternal and Child Health Consortium (MCHC)" means a voluntarily formed non-profit organization, consisting of all inpatient or ambulatory perinatal and pediatric care providers and related community organizations in a maternal and child health service region, as described at N.J.A.C. 8:35A.

"Maternal and child health service region" means the perinatal and pediatric service delivery area described at N.J.A.C. 8:33C.

"Medical record" means all records in the facility which pertain to the patient's health care.

"Medication" means a substance as defined by the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39. The word *"*drug*"* is used interchangeably with the word *"*medication*"* in this chapter.

"Monitor" means to observe, watch, or check.

"Plan of care" means a written plan which is based upon the patient assessments performed by all services participating in the patient's care and which includes care and treatment to be provided. Each professional discipline which provides care to the patient develops its own portion of the plan of care.

"Prescriber" means a person who is authorized to write prescriptions in accordance with Federal and State laws.

"Primary care" means the provision by a health care facility of preventive, diagnostic, treatment, management, and reassessment services to individuals with acute or chronic illness. The term is used in reference to facilities providing family practice, general internal medicine, general pediatrics, obstetrics, gynecology, and/or clinical preventive services, including community health centers providing comprehensive primary care. Comprehensive primary care may include the provision of sick and well care to all age groups, from perinatal and pediatric care to geriatric care. Primary care is further characterized by the fact that it represents the initial point of contact between an individual and the health care system, by the assumption of responsibility for the person regardless of the presence or absence of disease, by the ongoing responsibility for coordination of medical care for the person, by its family-centeredness, and by its community orientation.

"Satellite" means an affiliate of a separately licensed ambulatory care facility. A satellite is located at a site distinct from that of the separately licensed ambulatory care facility, but shares the same governing authority and provides the same principal service as the separately licensed ambulatory care facility.

"Secondary care" means care delivered by a specialist or subspecialist following referral by the primary care source. This may include ambulatory or inpatient care.

"Signature" means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D., D.O.) of a person, legibly written with his or her own hand. If electronic signatures are used, they shall be used in accordance with N.J.A.C. 8:43A-13.4.

"Staff education plan" means a written plan which describes a coordinated program for staff education for each service, including inservice programs and on-the-job training.

"Staff orientation plan" means a written plan for the orientation of each new employee to the duties and responsibilities of the service

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to which the employee has been assigned, as well as to the personnel policies of the facility.

"Sterilization" means a process of destroying all microorganisms, including those bearing spores, in, on, and around an object.

"Tertiary care" means specialized inpatient or outpatient care.

8:43A-1.4 Qualifications of the administrator of the ambulatory care facility

The administrator shall have a baccalaureate degree and two years of full-time, or full-time equivalent, administrative or supervisory experience in a health care facility. Each additional year of full-time, or full-time equivalent, administrative or supervisory experience and/or training in a health care facility may be substituted for each year of the four-year degree requirement. Four years of such experience and/or training may be used to satisfy the degree requirement.

8:43A-1.5 Qualifications of anesthesiologists

An anesthesiologist shall be a physician who has successfully completed a residency program in anesthesiology accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before *[1972]* ***1982***.

8:43A-1.6 Qualifications of certified nurse midwife

Each certified nurse midwife shall meet the requirements of the New Jersey State Board of Medical Examiners at N.J.A.C. 13:35-2A.

8:43A-1.7 Qualifications of certified registered nurse anesthetists (CRNA)

Each certified nurse anesthetist shall meet the requirements of the New Jersey State Board of Nursing at N.J.A.C. 13:37-13.

8:43A-1.8 Qualifications of dentists

Each dentist shall be so licensed by the New Jersey State Board of Dentistry.

8:43A-1.9 Qualifications of dietitians

Each dietitian shall be registered or eligible for registration by the Commission on Dietetic Registration (Office on Dietetic Credentialing, 216 W. Jackson Boulevard—7th Floor, Chicago, Illinois 60606-6995).

8:43A-1.10 Qualifications of the director of nursing services

The director of nursing services shall be a registered professional nurse and shall have at least one year of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a licensed health care facility.

8:43A-1.11 Qualifications of drug counselors

(a) Each drug counselor shall:

1. Be certified by the Alcohol and Other Drugs of Abuse *[Counsel or]* ***Counselor*** Certification Board of New Jersey, Inc. (90 Monmouth Street, Suite One, Red Bank, NJ 07701);

2. Be certified by the American Academy of Health Care Providers in the Addictive Disorders (260 Beacon Street, Somerville, MA 02143);

3. Be a social worker, in accordance with N.J.A.C. 8:43A-1.27;

4. Have a baccalaureate degree in a social science and one year of full-time equivalent experience in drug abuse counseling; or

5. Be currently enrolled in a program leading to one of the credentials required by (a)1 through 4 above and under the supervision of a person who has one of the credentials required by (a)1 through 4 above and at least three years of experience in drug counseling.

8:43A-1.12. Qualifications of family practice physicians

A family practice physician shall be a physician who has successfully completed a residency program in family practice accredited by the Accreditation Council for Graduate Medical Education or a residency program in general practice approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Family Practice or the American Osteopathic Board of General Practice.

8:43A-1.13 Qualifications of licensed practical nurses

Each licensed practical nurse shall be so licensed by the New Jersey State Board of Nursing.

8:43A-1.14 Qualifications of the medical director

The medical director shall be a physician who has successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association in a medical specialty related to services provided by the facility, or who is a diplomate of one of the certifying boards approved by the American Board of Medical Specialties or one of the certifying boards of the American Osteopathic Association in a medical specialty related to services provided by the facility. If the facility provides chronic dialysis services, the medical director shall be a nephrologist, in accordance with N.J.A.C. 8:43A-24.4(a).

8:43A-1.15 Qualifications of nephrologists

A nephrologist shall be a physician who has successfully completed a residency program in nephrology accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine in the subspecialty of nephrology.

8:43A-1.16 Qualifications of nurse practitioners

Each nurse practitioner shall be so certified by the New Jersey State Board of Nursing.

8:43A-1.17 Qualifications of obstetrician-gynecologists

An obstetrician-gynecologist shall be a physician who has successfully completed a residency program in obstetrics/gynecology accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.

8:43A-1.18 Qualifications of pediatricians

A pediatrician shall be a physician who has successfully completed a residency program in pediatrics accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

8:43A-1.19 Qualifications of pharmacists

Each pharmacist shall be so registered by the New Jersey State Board of Pharmacy.

8:43A-1.20 Qualifications of physician assistants

Each physician assistant shall be so licensed by the New Jersey State Board of Medical Examiners.

8:43A-1.21 Qualifications of physicians

(a) Each physician shall be licensed or authorized by the New Jersey State Board of Medical Examiners to practice medicine in the State of New Jersey.

(b) For any of the rules in this chapter requiring a physician to be Board-certified within his or her medical speciality, it shall be deemed acceptable to possess Board-certification from a foreign Board within the specified medical specialty where the American Board offers reciprocity with or officially recognizes the foreign board-certification credential.

8:43A-1.22 Qualifications of podiatrists

Each podiatrist shall be so licensed by the New Jersey State Board of Medical Examiners.

8:43A-1.23 Qualifications of radiation physicists/health physicists

Each radiation physicist/health physicist shall meet the requirements for certification as a specialist in radiation safety by the American Board of Radiology or the American Association of Physicists in Medicine, or shall have a master's degree with a major in medical radiation physics, health physics or radiologic health.

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8:43A-1.24 Qualifications of radiologic technologists

Each radiologic technologist shall be so licensed by the New Jersey State Department of Environmental Protection.

8:43A-1.25 Qualifications of radiologists

A radiologist shall be a physician who has successfully completed a residency program in radiology accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Radiology or the American Osteopathic Board of Radiology.

8:43A-1.26 Qualifications of registered professional nurses

Each registered professional nurse shall be so licensed by the New Jersey State Board of Nursing.

8:43A-1.27 Qualifications of social workers

Each social worker shall be certified or licensed by the New Jersey State Board of Social Work Examiners and shall comply with the Social Workers' Licensing Act of 1991 (N.J.S.A. 45:15BB***-1*** et seq.) and amendments thereto and with all rules of the New Jersey State Board of Social Work Examiners. Prior to the implementation by the Board of procedures for applying for certification or licensure, each social worker shall have a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (1744 R Street NW, Washington, D.C. 20036).

8:43A-1.28 Qualifications of urologists

A urologist shall be a physician who has successfully completed a residency program in urology accredited by the Accreditation Council for Graduate Medical Education or a residency program in urological surgery approved by the American Osteopathic Association, or who is a diplomate of either the American Board of Urology or the American Osteopathic Board of Surgery in the subspecialty of urological surgery.

SUBCHAPTER 2. LICENSURE PROCEDURES

8:43A-2.1 Certificate of need

(a) According to N.J.S.A. 26:2H-1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for, and receipt of, a certificate of need issued by the Commissioner.

(b) Application forms for a certificate of need and instructions for completion may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
CN 360
Trenton, New Jersey 08625

1. Application forms for a certificate of need in the case of transfer of ownership may be obtained from:

Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the certificate of need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:43A-2.2 Application for licensure

(a) Following receipt of a certificate of need or a determination that a certificate of need is not required, any person, organization, or corporation desiring to operate an ambulatory care facility shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from:

Director
Licensing, Certification and Standards
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625

(b) The Department shall charge a nonrefundable fee of $500.00 for the filing of an application for licensure of an ambulatory care facility and $500.00 for the initial license and annual renewal thereof. The licensing fee permits a facility to offer one of the services or centers listed in N.J.A.C. 8:43A-2.3(a) below. The facility shall submit an additional nonrefundable fee of $250.00 for each service or center listed in N.J.A.C. 8:43A-2.3(a) which is provided in addition to the principal service of the facility. For a single license, the total fee which may be assessed for the filing of an application for licensure and for the annual renewal of the license shall not exceed $2,000.

1. The Department shall charge a nonrefundable fee of $250.00 for the filing of an application for licensure of a satellite of a separately licensed ambulatory care facility and for the annual renewal of the satellite license. This fee permits a satellite to offer one of the services or centers listed in N.J.A.C. 8:43A-2.3(a) below. The satellite shall submit an additional nonrefundable fee of $250.00 for each service or center listed in N.J.A.C. 8:43A-2.3(a) which is provided in addition to the principal service of the satellite. For a single satellite license, the total fee which may be assessed for the filing of an application for licensure of the satellite and for the annual renewal of the license shall not exceed $2,000.

(c) Each applicant for a license to operate a facility shall complete all information requested on the licensure application. An appointment *[may]* ***for a preliminary conference shall*** be requested with the Licensing, Certification and Standards Program ***to review the conditions for licensure and operation*.**

(d) *[Each applicant] ***All applicants*** must demonstrate that they have the capacity to operate an ambulatory care facility in accordance with the rules in this chapter. An application for a license may be denied if the applicant cannot demonstrate that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care are fit and adequate and that there is reasonable assurance that the health care facility will be operated in accordance with the standards required by these rules. The Department may consider an applicant's prior history in operating a health care facility either in New Jersey or in other states in making this determination. Any evidence of licensure violations representing a serious risk of harm to patients may be considered by the Department, as well as any record of criminal convictions representing a risk of harm to the safety or welfare of patients.

8:43A-2.3 Types of services requiring a license

(a) None of the following services or centers shall be provided by an ambulatory care facility unless the facility license indicates that the service is provided by the facility:

1. Surgical center;
2. Family planning services;
3. Birth center;
4. Chronic dialysis services;
5. Diagnostic radiological center and/or magnetic resonance imaging services;
6. Extracorporeal shock wave lithotripsy services;
7. Drug abuse treatment services;
8. Primary care services, including family practice, pediatric, and/or prenatal, postpartum, or gynecological services; *[and]*
9. *[Physical]* ***Comprehensive*** rehabilitation services*[.]****; and**
10. Abortion facility.*

(b) The license issued by the Department shall specify the services which the facility is licensed to provide. The facility shall obtain a determination of the applicability of Certificate of Need rules prior to requesting that any service be added to the license. The facility shall provide only those services for which it is licensed or authorized to provide by the Department.

(c) Any person, organization, or corporation applying for a license to operate an ambulatory care facility shall specify on the application the services to be provided.

(d) As of the effective date of this chapter, each facility shall specify, upon annual renewal of its license, the types of services to be provided, if the facility wishes to change the specification of services on the facility license.

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(e) If a facility wishes to add any health care service during the annual licensure period, including any health care service not listed in (a) above, the facility shall obtain the authorization of the Licensing, Certification, and Standards Program of the Department prior to providing the additional service. Such authorization shall be based upon compliance with this chapter, and may be contingent upon an on-site inspection by representatives of the Department. This rule applies regardless of whether or not it is determined that a Certificate of Need is required.

8:43A-2.4 Newly constructed or expanded facilities

(a) Any ambulatory care facility which intends to undertake any alteration, renovation, or new construction of the physical plant, whether a Certificate of Need is required or not, shall submit plans to the Health Facilities Construction Services of the Department for review and approval prior to the initiation of any work, in accordance with N.J.A.C. 8:43A-19.

(b) The licensure application for a newly constructed or expanded facility shall include written approval of final construction of the physical plant by:

Health Facilities Construction Services
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625

(c) An on-site inspection of the construction of the physical plant shall be made by representatives of Health Facilities Construction Services to verify that the building has been constructed in accordance with the architectural plans approved by the Department.

8:43A-2.5 Surveys and temporary license

(a) When the written application for licensure is approved and the building is ready for occupancy, a survey of the facility by representatives of the Health Facilities Inspection Program of the Department shall be conducted to determine if the facility complies with the rules in this chapter.

1. The facility shall be notified in writing of the findings of the survey, including any deficiencies found.

2. The facility shall notify the Health Facilities Inspection Program of the Department when the deficiencies, if any, have been corrected, and the Health Facilities Inspection Program will schedule one or more resurveys of the facility prior to occupancy.

(b) A temporary license may be issued to a facility when the following conditions are met:

1. A preliminary conference (see N.J.A.C. 8:43A-2.2(c)) for review of the conditions for licensure and operation*, **unless determined by the Department to be unnecessary,*** has taken place between the Licensing, Certification and Standards Program and representatives of the facility, who will be advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with N.J.S.A. 26:2H-1 et seq. and the rules pursuant thereto;

2. Written approvals are on file with the Department from the local zoning, fire, health and building authorities;

3. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system; and

4. Survey(s) by representatives of the Department indicate that the facility complies with the rules in this chapter.

(c) No facility shall admit patients to the facility until the facility has the written approval and/or license issued by the Licensing, Certification and Standards Program of the Department.

(d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and patient records and conferences with patients.

(e) A temporary license may be issued to a facility for a period of six months and may be renewed as determined by the Department.

(f) The temporary license shall be conspicuously posted in the facility.

(g) The temporary license is not assignable or transferable, and it shall be immediately void if the facility ceases to operate or if its ownership changes.

8:43A-2.6 Full license

(a) A full license shall be issued on expiration of the temporary license, if surveys by the Department have determined that the facility is operated as required by N.J.S.A. 26:2H-1 et seq. and by the rules pursuant thereto.

(b) A license shall be granted for a period of one year or less, as determined by the Department.

(c) The license shall be conspicuously posted in the facility.

(d) The license is not assignable or transferable, and it shall be immediately void if the facility ceases to operate or if its ownership changes.

(e) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

(f) The license may not be renewed if local rules, regulations, and/or requirements are not met, in accordance with the provisions of N.J.A.C. 8:43A-2.10(a).

8:43A-2.7 Conditional license

A conditional license may be issued to a health care facility providing a type or category of health care service neither listed in N.J.A.C. 8:43A-2.3(a) nor otherwise addressed by this chapter. The facility shall comply with the standards set forth as a condition of the license.

8:43A-2.8 Surrender of license

The facility shall notify each patient, each patient's physician, and any guarantors of payment at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Licensing, Certification and Standards Program of the Department within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

8:43A-2.9 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of N.J.S.A. 26:2H-1 et seq. and the rules in this chapter, waive sections of these rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

(b) A facility seeking a waiver of these rules shall apply in writing to the Director of the Licensing, Certification and Standards Program of the Department.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;

2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon compliance;

3. An alternative proposal which would ensure patient safety; and

4. Documentation to support the request for waiver.

(d) The Department reserves the right to request additional information before processing a request for waiver.

8:43A-2.10 Action against a license

(a) If the Department determines that operational or safety deficiencies exist, it may require that all admissions to the facility or to services provided within the facility cease. This may be done simultaneously with, or in lieu of, action to revoke licensure and/or impose a fine. The Commissioner or his or her designee shall notify the facility in writing of such determination.

(b) The Commissioner may order the immediate removal of patients from a facility whenever he or she determines that there exists imminent danger to any person's health or safety.

(c) The provisions of this section shall apply to facilities with a temporary license and to facilities with a full license.

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(d) The Commissioner may issue a penalty on a facility for violation of licensure requirements of this chapter pursuant to N.J.S.A. 26:2H-13 and 14.

(e) The Commissioner may suspend or revoke the license of a facility for failure to correct any violation of this chapter posing an imminent harm to patients pursuant to N.J.S.A. 26:2H-14.

8:43A-2.11 Hearings

(a) If the Department proposes to suspend, revoke, deny, or refuse to renew a license or authorization, the licensee or applicant may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) Prior to transmittal of any hearing request to the Office of Administrative Law, the Department may schedule a conference to attempt to settle the matter.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:43A-3.1 Provision of services

(a) The facility shall provide preventive, diagnostic, and/or treatment services to patients. Medical services and nursing services, as required by this chapter, shall be provided in the facility. Medical services, nursing services, counseling services, pharmaceutical services, and laboratory and radiological services shall be provided directly by the facility or through written agreement.

(b) The facility shall have a written agreement for services not provided directly by the facility. The written agreement shall specify each party's responsibilities. If the service is provided in the facility, the written agreement shall require that services be provided in accordance with the rules in this chapter. If the service is provided outside of the facility, the written agreement shall require the provision of written documentation to the facility, including, but not limited to, documentation of services rendered and recommendations made by the party providing the service.

8:43A-3.2 Compliance with laws and rules

(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.

(b) If a health care facility licensed by the Department provides ambulatory care services in addition to other health care services, the facility shall comply with the rules in this chapter and with the rules for licensure of facilities which provide the other health care services.

8:43A-3.3 Ownership

(a) The ownership of the facility and the property on which it is located shall be disclosed to the Department. Proof of this ownership shall be available in the facility or at a designated location. Any proposed change in ownership shall be reported to the Director of the Licensing, Certification and Standards Program of the Department in writing at least 30 days prior to the change and in conformance with requirements for Certificate of Need applications.

(b) No facility shall be owned, managed, or operated by any person convicted of a crime relating adversely to the person's capability of owning, managing, or operating the facility.

8:43A-3.4 Submission of documents and data

(a) The facility shall, upon request, submit in writing any documents which are required by the rules in this chapter to the Director of the Licensing, Certification and Standards Program of the Department.

(b) The facility shall collect and submit to the Department, upon request, at least the following statistical data:

1. Number of patient visits, by payment source;
2. Number of distinct patients served, by payment source;
3. Number of new patients accepted; and
4. Number of practitioners, by type and level, providing services in the facility.

8:43A-3.5 Personnel

(a) The facility shall develop written job descriptions and ensure that personnel are assigned duties based upon their education, training, and competencies, and in accordance with their job descriptions.

(b) All personnel who require licensure, certification, or authorization to provide patient care shall be currently licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey or under the applicable standards of the appropriate body.

(c) Staffing schedules shall be implemented to ensure continuity of care to patients. Provision shall be made for substitute staff with equivalent qualifications to replace absent staff members.

(d) The facility shall develop and implement a staff orientation plan and a staff education plan, including plans for each service and designation of person(s) responsible for training.

1. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control program, universal precautions, policies and procedures concerning patient rights, and, if appropriate, given the patient population of the facility, identification of cases of child abuse and/or elder abuse.

(e) At least one person who is currently certified in basic cardiac life support by the American Heart Association or the American Red Cross, or currently certified by the Department as an emergency medical technician—ambulance (EMT-A), shall be in the facility at all times during the facility's hours of operation. If a cardiac rehabilitation program is provided, at least one person who is currently certified in advanced cardiac life support by the American Heart Association shall be in the facility at all times during the facility's hours of operation.

8:43A-3.6 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following:

1. A written statement describing the program's treatment philosophy, objectives, and staffing patterns, and the services provided by the facility;
2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and patient care services of the facility;
3. A description of the quality assurance program for patient care and staff performance, including methods for at least annual review of staff qualifications and credentials and of staff orientation and education;
4. Definition and specification of hours of operation, including all times in which patients are present in the facility, business hours, and full working week;
5. A system for referral of patients to sources of secondary and tertiary health care;
6. A requirement for at least one member of the medical staff to maintain admitting privileges at a hospital;
7. Policies and procedures for the maintenance of personnel records for each employee, including at least the employee's name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of staff orientation and staff education, and evaluations of job performance; ***and***
8. Policies and procedures for complying with applicable statutes and protocols to report child abuse and/or neglect, abuse or mistreatment of elderly or disabled adults, sexual abuse, specified communicable disease, rabies, poisonings, and unattended or suspicious deaths. These policies and procedures shall include, but not be limited to, the following:

i. The designation of a staff member(s) to be responsible for coordinating the reporting of diagnosed and/or suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6-1 et seq.,

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recording the notification to the Division of Youth and Family Services in the medical record, and serving as a liaison between the facility and the Division of Youth and Family Services;

ii. The notification of any suspected case of patient abuse or exploitation to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly, pursuant to N.J.S.A. 52:27G-7.1 et seq., if the patient is 60 years of age or older;

iii. The development of written protocols for the identification and the treatment of children and elderly or disabled adults who are abused and/or neglected; and

iv. The provision at least annually of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect; sexual abuse; domestic violence; abuse of the elderly or disabled adult; and the facility's policies and procedures.

Note: Copies of N.J.S.A. 9:6-1 et seq. can be obtained from the local district office of the Division of Youth and Family Services (DYFS) or from the Office of Program Support, Division of Youth and Family Services, New Jersey State Department of Human Services, CN 717, Trenton, New Jersey 08625.

(b) The policy and procedure manual(s) shall be available and accessible to all patients, staff, and the public.

8:43A-3.7 Employee health

(a) The policy and procedure manual of the facility shall include policies and procedures to ensure that physical examinations of employees are performed upon employment and subsequently. Policies and procedures shall specify the circumstances under which other persons providing direct patient care services shall receive a physical examination. Policies and procedures shall specify the content and the frequency of the examinations.

(b) Each employee who cannot document the result of a previous rubella screening test shall be given a rubella screening test using the rubella hemagglutination inhibition test or other rubella screening test approved by the Department. Each new employee who cannot document the result of a previous rubella screening test shall be given the rubella screening test upon employment. An employee who can document seropositivity from a previous rubella screening test or who can document inoculation with rubella vaccine shall not be required to have a rubella screening test.

1. Each employee tested shall be informed in writing by the facility of the results of his or her rubella screening test.

2. Each employee's personnel record shall contain documentation of all tests performed and the results.

3. A list shall be maintained of all employees who are seronegative and unvaccinated, to be used in the event that an employee is exposed to rubella and a determination is needed as to whether or not the employee may continue to work.

(c) Each employee born in 1957 or later shall be given a measles (rubeola) screening test using the hemagglutination inhibition test, or other rubeola screening test, within six months of the effective date of this chapter. Each new employee born in 1957 or later shall be given a measles (rubeola) screening test upon employment. An employee who can document receipt of a live measles vaccine on or after the first birthday, physician-diagnosed measles, or serologic evidence of immunity shall not be required to have a measles (rubeola) screening test.

1. Each employee tested shall be informed in writing by the facility of the results of his or her measles (rubeola) screening test.

2. Each employee's personnel record shall contain documentation of all tests performed and the results.

3. A list shall be maintained of all employees who are seronegative and unvaccinated.

(d) Each employee, including members of the medical staff employed by the facility, shall receive a Mantoux tuberculin skin test with five tuberculin units of purified protein derivative within six months of the effective date of this chapter. Each new employee shall be given a Mantoux tuberculin skin test upon employment. Subsequent tests shall be performed in accordance with facility policy. Employees who can document negative Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees who can document positive Mantoux skin test results (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, and employees for whom a Mantoux skin test is medically contraindicated shall not be required to receive a Mantoux tuberculin skin test.

1. If the Mantoux tuberculin skin test reaction is between zero and nine millimeters of induration, the test shall be repeated one to three weeks later.

2. If the Mantoux tuberculin skin test reaction is 10 or more millimeters of induration, a chest X-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy.

(e) The policy and procedure manual of the facility shall address employee safety and shall include procedures for the care of employees who become ill at the facility or who are injured at the facility.

8:43A-3.8 Reportable events

(a) The facility shall notify the Department immediately by telephone at (609) 588-7725, or at (609) 392-2020 after business hours, of any event occurring within the facility which jeopardizes the health or safety of patients or employees. Events which shall be reported to the Department include, but are not limited to, the following:

1. All fires, disasters, accidents or other unanticipated events which result in serious injury or death of patients or staff, in evacuation of patients from the facility, or in closure of the facility for six or more hours;

2. All deaths of patients occurring in the facility;

3. Occurrence of epidemic disease in the facility; and

4. All alleged or suspected crimes which endanger the life or safety of patients or staff and which have also been reported at the time of occurrence to the local police department.

(b) Events reported by telephone to the Department in accordance with this section shall be confirmed in writing within seven days of the event, unless the Department determines that a written report is unnecessary. The written report shall contain information concerning injuries to patients or staff, disruption of services, extent of damages, and corrective actions taken.

(c) Resignation or termination of employment of the administrator, and the name and qualifications of the administrator's replacement, shall be reported to the Department in writing within seven days of the resignation or termination.

8:43A-3.9 Notices

(a) The facility shall conspicuously post a notice that the following information is available in the facility during business hours to patients and the public:

1. All waivers granted by the Department;

2. The list of deficiencies from the last annual licensure inspection and certification survey report (if applicable), and the list of deficiencies from any valid complaint investigation during the past 12 months;

3. A statement of patient rights;

4. The names of the members of the governing authority; and the addresses to which correspondence may be sent; and

5. The hours of operation and the business hours of the facility.

8:43A-3.10 Information reportable to State Board of Medical Examiners

(a) In accordance with the Professional Medical Conduct Reform Act, P.L. 1989, c.300, the facility shall notify the Medical Practitioner Review Panel established by the New Jersey State Board of Medical Examiners if a practitioner who is employed by, who is under contract to render professional services to, or who has privileges at the facility:

1. Voluntarily resigns from the staff if the facility is reviewing the practitioner's conduct or patient care or has expressed, through any member of the medical or administrative staff, an intention to do so;

2. Voluntarily relinquishes any partial privileges to perform a specific procedure if the facility is reviewing the practitioner's conduct or patient care or has expressed, through any member of the medical or administrative staff, an intention to do so;

3. Has full or partial privileges summarily or temporarily revoked or suspended, permanently reduced, suspended or revoked, has been

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discharged from the staff or has had a contract to render professional services terminated or rescinded for reasons relating to the practitioner's incompetency, misconduct, or impairment;

4. Agrees to the placement of conditions or limitations on the exercise of clinical privileges or practice within the health care facility including, but not limited to, second opinion requirements, nonroutine concurrent or retrospective review of admissions or care, nonroutine supervision by one or more members of the staff, or the completion of remedial education or training;

5. Is granted a leave of absence pursuant to which the practitioner may not exercise clinical privileges or practice within the facility and if the reasons provided in support of the leave relate to any physical, mental, or emotional condition or drug or alcohol abuse, which might impair the practitioner's ability to practice with reasonable skill and safety; or

6. Is a party to a medical malpractice liability suit in which the facility is also a party and in which there is a settlement, judgement, or arbitration award.

(b) For the purposes of (a) above, "practitioner" means physician, medical resident or intern, or podiatrist.

(c) Notifications required by (a) above shall be provided within seven days of the date of the action, settlement, judgement or award and shall be submitted on forms approved by the Department of Health for that purpose. The facility shall submit a completed supplemental form to the New Jersey State Board of Medical Examiners if so requested by the Board.

8:43A-3.11 Reporting to professional licensing boards

The facility shall comply with all requirements of the professional licensing boards for reporting termination, suspension, revocation, or reduction of privileges of any health professional licensed in the State of New Jersey.

SUBCHAPTER 4. GOVERNING AUTHORITY

8:43A-4.1 Responsibility of the governing authority

(a) The facility shall have a governing authority which shall assume legal responsibility for the management, operation, and financial viability of the facility. The governing authority shall be responsible for, but not limited to, the following:

1. Services provided and the quality of care rendered to patients;

2. Provision of a safe physical plant equipped and staffed to maintain the facility and services;

3. Adoption and documented review of writtenby laws, or their equivalent, in accordance with a schedule established by the governing authority;

4. Appointment, reappointment, assignment of privileges, and curtailment of privileges of health care professionals, and written confirmation of such actions;

5. Ensuring development and review of all policies and procedures in accordance with a schedule established by the governing authority;

6. Establishment and implementation of a system whereby patient and staff grievances and/or recommendations, including those relating to patient rights, can be identified within the facility. This system shall include a feedback mechanism through management to the governing authority, indicating what action was taken;

7. Determination of the frequency of meetings of the governing authority and its committees, or equivalent, conducting such meetings, and documenting them through minutes;

8. Delineation of the duties of the officers of any committees, or equivalent, of the governing authority. When the governing authority establishes committees, their purpose, structure, responsibilities, and authority, and the relationship of the committee to other entities within the facility, shall be documented;

9. Establishment of the qualifications of members and officers of the governing authority, the procedures for electing and *[appointment]* ***appointing*** officers, and the terms of service for members, officers, and committee chairpersons or equivalent; and

10. Approval of the medical staff bylaws or equivalent.

SUBCHAPTER 5. ADMINISTRATION

8:43A-5.1 Appointment of administrator

The governing authority shall appoint an administrator who shall be accountable to the governing authority. The administrator, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available in the facility during its hours of operation.

8:43A-5.2 Administrator's responsibilities

(a) The administrator shall be responsible for, but not limited to, the following:

1. Ensuring the development, implementation, and enforcement of all policies and procedures, including patient rights;

2. Planning for, and administration of, the managerial, operational, fiscal, and reporting components of the facility;

3. Participating in the quality assurance program for patient care and staff performance;

4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions;

5. Ensuring the provision of staff orientation and staff education; and

6. Establishing and maintaining liaison relationships and communication with facility staff and services, with support services and community resources, and with patients.

SUBCHAPTER 6. PATIENT CARE POLICIES AND SERVICES

8:43A-6.1 Establishment and implementation of policies and procedures

The facility shall establish and implement written patient care policies and procedures governing the services provided.

8:43A-6.2 Patient care policy committee

(a) The facility shall establish a patient care policy committee, or its equivalent, consisting of, but not limited to, the administrator, the medical director, and a representative of the nursing service. A representative of each service offered by the facility shall attend all patient care policy committee meetings in which policies or procedures for that particular service are developed or reviewed.

(b) All patient care policies and procedures shall be reviewed by the patient care policy committee, in accordance with a schedule established by the governing authority, at least triennially. Each review shall be documented.

8:43A-6.3 Policies and procedures

(a) Patient care policies and procedures shall facilitate continuity of care to patients and shall include, but not be limited to, policies and procedures concerning the following:

1. Services to be provided, including preventive, diagnostic, and treatment services;

2. Patient rights;

3. The referral of patients to other health care providers and the use of consultant services, in order to provide a continuum of care for the patient;

4. The provision of emergency and after-hours care and treatment, including a definition of emergency;

5. Methods for obtaining and documenting informed consent, including definition or a listing of types of procedures for which informed consent will be required;

6. Advance directives, including, but not limited to, the following:

i. The circumstances under which an inquiry will be made of adult individuals receiving surgical services, anesthesia services other than minor conduction block, or chronic dialysis services regarding the existence and location of an advance directive;

ii. Requirements for provision of a written statement of patient rights regarding advance directives, approved by the Commissioner or his or her designee, to such patients upon admission; and

iii. Requirements for documentation in the medical record;

7. Admission of patients, including limitations on admission based on diagnosis, type or degree of disability, medical condition, patient age, or other factors. These limitations shall not conflict with appli-

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cable Federal and State laws prohibiting discrimination in the admission of patients or in the provision of health care services;

8. The facility's registration and appointment system;

9. Follow-up of broken appointments, including specification of the circumstances under which such follow-up will be performed;

10. The provision of screening services, if offered, including indications for, and frequency of, such services;

11. Medical histories and physical examinations;

12. Initiation, implementation, review, and revision of a written plan of care, including indication of the types of patients for whom a plan of care will be written;

13. A system whereby, whenever possible, the patient is cared for by the same health care professionals;

14. Methods for ensuring visual and auditory privacy of patients;

15. Immunization records, if applicable;

16. Patient instruction and health education;

17. The provision of telephone consultation to patients during the facility's hours of operation;

18. Discharge, termination by the facility, transfer, and readmission of patients, including criteria for each;

19. The safe-keeping of patients' valuables, when required; and

20. Other activities, as required by this chapter.

(b) All patient care policies and procedures shall be available within the facility.

8:43A-6.4 Medical history and physical examination

(a) The facility shall specify in its policies and procedures the circumstances under which the patient's medical history will be obtained, the contents of the medical history, and the frequency of updating. The contents shall include at least past surgical procedures and medical/health conditions, allergies, adverse reactions to drugs, and current medications.

(b) The facility shall specify in its policies and procedures the circumstances under which a physical examination will be performed, the frequency, and the contents. The contents shall include at least an assessment of body systems.

8:43A-6.5 Instructions and information for patients

The facility shall provide printed and/or written instructions and information for patients, with multilingual instructions as indicated. Information shall include, but not be limited to, tests and/or procedures needed, possible complications, a telephone number to call when needed, and instructions for obtaining care in an emergency.

8:43A-6.6 Communication assistance

The facility shall provide interpretation services, when necessary, for patients who do not speak English and for patients who are deaf. The facility shall provide other communication assistance, as needed, for patients who are blind.

8:43A-6.7 Suitability of equipment and supplies

The facility shall provide equipment and supplies which are appropriate to the treatment needs of patients of the types and ages served by the facility.

8:43A-6.8 Financial arrangements

(a) Records shall be maintained of all financial arrangements with patients, with copies furnished to the patient. The policies and procedures of the facility shall specify the form of retention and the retention schedule.

(b) Patients shall be informed, in advance, of the fees which are charged by the facility for the types of services and supplies expected to be provided to the patient, on the basis of a predetermined fee schedule. The facility shall post the fee schedule or a notice that the schedule is available in the facility. Patients shall be notified if physician or other practitioner fees will be billed separately.

(c) Policies and procedures shall require physicians and other practitioners to disclose, in advance, any separate charges, upon request of the patient.

(d) No additional charges, expenses, or other financial liabilities shall be assessed in excess of the predetermined rate, except:

1. Upon written approval and authority of the patient, who shall be given a copy of the written approval; or

2. In the event of a health emergency involving the patient and requiring immediate, special services or supplies to be furnished during the period of the emergency.

(e) Agreements with third-party payors and/or other payors, referral systems for patients' financial assistance, and sources of financial assistance available to the patient shall be described for the patient.

(f) Any sliding fee scales or special payment plans established by the facility shall be described and shall be made available for the patient to review upon the patient's request.

8:43A-6.9 Smoking in facility

The facility shall become smoke-free within three months of the effective date of this section. "Smoke-free" means a total ban on smoking in the facility by employees, visitors, and patients. Prior to the time at which the facility becomes smoke-free, the policy of the facility regarding smoking in the facility shall be in accordance with N.J.S.A. 26:3D-1 et seq.

8:43A-6.10 Calibration of instruments

All instruments of measurement shall be calibrated in accordance with manufacturers' instructions. A record of instrument calibration shall be maintained.

8:43A-6.11 Acupuncture services

If the facility provides acupuncture services, such services shall be provided in accordance with N.J.S.A. 45:2C-1 et seq.

SUBCHAPTER 7. MEDICAL SERVICES

8:43A-7.1 Provision of medical services

Medical services, as required by this chapter, shall be provided in the facility. Medical services shall be provided directly by the facility or through written agreement. Patients may be referred to physicians outside of the facility for additional medical services as required to provide a continuum of care for the patient.

8:43A-7.2 Designation of medical director

The governing authority shall designate a physician to serve as medical director. The medical director shall designate, in writing, a physician to act in the absence of the medical director. The medical director, or his or her designee, shall be available to the facility at all times.

8:43A-7.3 Medical director's responsibilities

(a) The medical director shall be responsible for the direction, provision, and quality of medical services provided to patients. He or she shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the medical service. All medical policies and procedures shall be reviewed at least annually;

2. Participating in planning and budgeting for the medical service;

3. Coordinating and integrating the medical service with other patient care services to provide a continuum of care for the patient;

4. Ensuring that medical staffing patterns are implemented;

5. If the facility provides a cardiac rehabilitation program, ensuring that a physician is present in the facility at all times during the facility's hours of operation to supervise nonphysician personnel;

6. Assisting in developing and maintaining written job descriptions for the medical staff, participating in the review of credentials and delineation of privileges of medical staff members, and assigning duties based upon education, training, competencies, and job descriptions;

7. Participating in staff orientation and staff education activities; and

8. Approving the contents, locations, and frequency of checking contents, including expiration dates, of emergency kits or carts, equipment, and supplies, and assigning responsibility for these checks.

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8:43A-7.4 Medical policies and medical staff bylaws

(a) The medical director shall be responsible for developing, implementing, and reviewing written medical policies, including medical staff bylaws, in cooperation with the medical staff. These shall be approved by the governing authority and shall include, but not be limited to, the following:

1. A plan for medical staff meetings and their documentation through minutes;

2. A mechanism for establishing and implementing procedures relating to credentials review, delineation of qualifications, medical staff appointments and reappointments, evaluation of medical care, and the granting, denial, curtailment, suspension, or revocation of medical staff privileges;

3. Specifications for verbal orders, including who may give verbal orders and who may receive them; and

4. A system for completion of entries in the patient medical record by members of the medical staff, including, but not limited to, specification of a time limit for completion of the medical record, not to exceed 30 days following the patient's last treatment or discharge. Entries shall be signed in accordance with N.J.A.C. 8:43A-13.4 and the facility's policies and procedures.

SUBCHAPTER 8. NURSING SERVICES

8:43A-8.1 Provision of nursing services

Nursing services, as required by this chapter, shall be provided in the facility. Nursing services shall be provided directly by the facility or through written agreement.

8:43A-8.2 Designation of director of nursing services

The facility shall designate in writing a registered professional nurse as the director of nursing services, who shall be on the premises of the facility during its hours of operation. A registered professional nurse shall be designated in writing to act in the absence of the director of nursing services.

8:43A-8.3 Responsibilities of director of nursing services

(a) The director of nursing services shall be responsible for the direction, provision, and quality of nursing services provided to patients. The director of nursing services shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the nursing service. All nursing policies and procedures shall be reviewed at least annually;

2. Participating in planning and budgeting for the nursing service;

3. Coordinating and integrating the nursing service with other patient care services to provide a continuum of care for the patient;

4. Ensuring that nursing staffing patterns are implemented;

5. Assisting in developing and maintaining written job descriptions for nursing personnel, and assigning duties based upon education, training, competencies, and job descriptions; and

6. Participating in staff orientation and staff education activities.

8:43A-8.4 Responsibilities of licensed nursing personnel

(a) Licensed nursing personnel shall provide nursing care to patients in accordance with the State of New Jersey Nursing Practice Act, N.J.S.A. 45:11-23 et seq., as interpreted by the New Jersey State Board of Nursing, and written job descriptions. Services provided shall be documented in the patient's medical record.

(b) The nursing care needs of the patient shall be assessed only by a registered professional nurse.

8:43A-8.5 Nursing portion of the medical record

(a) In accordance with written job descriptions and with these rules, nursing personnel shall enter the following in the patient's medical record:

1. The nursing portion of the patient plan of care, in accordance with the facility's policies and procedures;

2. Clinical notes; and

3. A record of medications administered. After each drug administration, the following shall be documented by the nurse who administered the drug: name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the nurse who administered the drug.

SUBCHAPTER 9. PHARMACEUTICAL SERVICES

8:43A-9.1 Provision of pharmaceutical services through an institutional pharmacy

(a) If the facility has an institutional pharmacy, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy and shall possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the Department in accordance with the Controlled Dangerous Substances Acts.

(b) If the facility has an institutional pharmacy, the facility shall designate a pharmacist who shall be responsible for the direction, provision, and quality of pharmaceutical services. The pharmacist shall be responsible for, but not limited to, the following:

1. Together with the patient care policy committee, developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the pharmaceutical service;

2. Participating in planning and budgeting for the pharmaceutical service;

3. Coordinating and integrating the pharmaceutical service with other patient care services to provide a continuum of care for the patient; and

4. Assisting in developing and maintaining written job descriptions for pharmacy personnel, if any, and assigning duties based upon education, training, competencies, and job descriptions.

8:43A-9.2 Scope

N.J.A.C. 8:43A-9.3 through 9.5 shall apply to all ambulatory care facilities, regardless of whether or not the facility has an institutional pharmacy.

8:43A-9.3 Policies and procedures

(a) The facility shall develop and implement written policies and procedures, approved by the patient care policy committee, for the administration, control, and storage of medications. The patient care policy committee shall review the policies and procedures and document the review at least annually.

(b) The facility's policies and procedures for the administration, control, and storage of medications shall include, but not be limited to, policies and procedures for the following:

1. Documenting and reviewing adverse drug reactions and medication errors;

2. Discontinuing drug orders, including, but not limited to, the length of time drug orders may be in effect, for drugs not specifically limited as to duration of use or number of doses when ordered, including intravenous infusion solutions;

3. The control of the administration of toxic and dangerous drugs, including at least narcotics, sedatives, anticoagulants, antibiotics, oxytoxics, corticosteroid products, intravenous infusion solutions, and other drugs specified in the facility's policies and procedures;

4. The use of parenterals, if used, including the labeling of intravenous infusion solutions, such that a supplementary label is affixed to the container of any intravenous infusion solution to which drugs are added;

5. The purchase, storage, safeguarding, accountability, use, and disposition of drugs, in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and the Controlled Dangerous Substances Acts and amendments thereto*. **Pharmaceutical services provided through written agreement shall be provided by a pharmacy licensed by the New Jersey State Board of Pharmacy. An individual patient may choose to obtain medications from a pharmacy which is not located in New Jersey***;

6. The procurement, storage, use, and disposition of needles and syringes in accordance with all applicable Federal and State laws and rules, including those specified at N.J.A.C. 8:43A-14.6(b). All needles and syringes shall be kept in locked storage areas;

7. The control of drugs subject to the Controlled Dangerous Substances Acts and amendments thereto, in compliance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and all

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other Federal and State laws and regulations concerning procurement, storage, dispensing, administration, and disposition. Such policies and procedures shall include, but not be limited to, the following:

i. Provision for a verifiable record system for controlled drugs;

ii. Policies and procedures to be followed in the event that the inventories of controlled drugs cannot be verified or drugs are lost, contaminated, unintentionally wasted, or destroyed. A report of any such incident shall be written and signed by the persons involved and any witnesses present; and

iii. In all areas of the facility where drugs are dispensed, administered, or stored, procedures for the intentional wasting of controlled drugs, including the disposition of partial doses, and for documentation, including the signature of a second person who shall witness the disposition;

8. The security of the keys or codes to locked drug storage areas, including specification of the personnel who may retain the keys or security codes. Only licensed nursing or medical personnel shall retain the keys or security codes to storage areas in which drugs subject to the Controlled Dangerous Substances Acts and amendments thereto are kept;

9. The control and limitation of use of drugs marked "sample";

10. The maintenance of records of prescribers' Controlled Dangerous Substance registration numbers and Drug Enforcement Administration registration numbers for New Jersey; and

11. Up-to-date pharmaceutical reference materials to be provided at locations specified in the facility's policies and procedures and made available to medical and nursing staff.

i. The telephone number of the designated Statewide or regional New Jersey Poison Information and Education System (1-800-962-1253) shall be provided at locations specified in the facility's policies and procedures.

ii. Current Federal and State drug law information shall be available to the pharmaceutical service.

iii. A list of abbreviations, metric apothecary conversion charts, and a list of chemical symbols, approved by the medical staff, shall be kept in areas where medications are prepared for administration.

8:43A-9.4 Administration of medications

(a) All medications administered shall be prescribed in writing. Each written order shall specify the name of the drug, dose, frequency, and route of administration and shall be signed and dated by the prescriber.

(b) Medications shall be dispensed only in accordance with prescriber orders and all Federal and State laws and rules. Medications shall be administered only in accordance with prescriber orders, medical staff policy, and all Federal and State laws and rules by licensed or authorized medical, dental, or nursing personnel.

(c) Medications shall not be removed from their original prescription containers until the time of drug administration.

(d) Each patient shall be identified prior to drug administration.

(e) Drugs dispensed for one patient shall not be administered to another patient.

(f) Drug allergies shall be documented in the patient's medical record and on its outside front cover. Other allergies shall be documented in the patient's medical record.

(g) Medication errors and adverse drug reactions shall be reported immediately to the nurse in charge and to the prescriber, and an entry shall be made in the patient's medical record. The incident shall be reported in accordance with procedures established by the facility. The incident shall be reported to the pharmacy, in accordance with policies and procedures approved by the patient care policy committee.

8:43A-9.5 Storage of drugs

(a) All drugs, except intravenous infusion solutions, shall be kept in locked storage areas. Drug storage and preparation areas shall be kept locked when not in use.

(b) All drugs shall be stored under proper conditions, as indicated by the United States Pharmacopoeia, product labeling, and/or package inserts.

(c) Drugs for external use shall be kept separate from drugs for internal use.

(d) All drugs in Schedule II of the Controlled Dangerous Substances Acts and amendments thereto shall be stored in a separate, locked, permanently affixed compartment within the locked medication cabinet, medication room, refrigerator, or mobile medication cart.

(e) A declining inventory of all drugs in Schedules I through V of the Controlled Dangerous Substances Acts and amendments thereto shall be made at the termination of each shift and shall be retained wherever these drugs are maintained.

(f) Drugs in single dose or single use containers which are open or which have broken seals, drugs in containers missing drug source or exact identification (such as lot number), and outdated, recalled, or visibly deteriorated medications shall be returned to the institutional pharmacy for disposal. In the absence of an institutional pharmacy, such drugs shall be brought to a location specified in the facility's policies and procedures for disposal in accordance with Federal and State laws.

SUBCHAPTER 10. COUNSELING SERVICES

8:43A-10.1 Provision of counseling services

(a) The facility shall provide, directly or through written agreement or through a documented referral mechanism, dietary counseling and social work services. All patients who have been identified as needing, or who have requested, other counseling services such as, but not limited to, genetic, psychological, and drug abuse counseling shall be referred to appropriate providers.

(b) The facility shall establish and implement written policies and procedures concerning the identification of the need for counseling services and referral to counseling services. The policies and procedures, which shall be reviewed at least annually, shall include, but not be limited to, policies and procedures for the following:

1. The provision, direction, and method to assure the quality of counseling services provided to patients;

2. The development and implementation of written objectives, standards of practice, and an organizational plan for counseling services;

3. Coordinating and integrating the counseling services with other patient care services in the facility and with services in the community to provide a continuum of care for the patient;

4. Staff orientation and staff education programs for the counseling staff; and

5. Entering in the patient's medical record:

i. The counseling service elements of the patient plan of care; and

ii. Clinical notes.

8:43A-10.2 Provision of social work services

Social work services which fall within the scope of practice defined by the Social Workers' Licensing Act of 1991 (N.J.S.A. 45:15BB-1 et seq.) and the New Jersey State Board of Social Work Examiners shall be provided by a social worker.

8:43A-10.3 Provision of dietary counseling

Dietary counseling which falls outside of the scope of practice defined by the State of New Jersey Nursing Practice Act and the New Jersey State Board of Nursing shall be provided by a dietitian.

SUBCHAPTER 11. LABORATORY AND RADIOLOGICAL SERVICES

8:43A-11.1 Provision of laboratory and radiological services

(a) The facility shall provide laboratory and radiological services directly or through written agreement.

(b) Laboratory services shall be provided only by facilities which are licensed or approved by the Department, in accordance with N.J.A.C. 8:44 and 8:45.

(c) Radiological services shall be provided only by facilities which are registered by the New Jersey State Department of Environmental Protection, Bureau of Radiological Health, in accordance with N.J.A.C. 7:28.

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(d) The facility shall establish and implement policies and procedures for obtaining, identifying, storing, and transporting laboratory specimens.

SUBCHAPTER 12. SURGICAL AND ANESTHESIA SERVICES

8:43A-12.1 Services

(a) (No change.)

(b) Surgical procedures requiring *[overnight care]* ***the patient to remain in the facility for more than 24 hours*** shall not be performed in the facility.

8:43A-12.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

"Supervision" means responsibility by a physician who is credentialed in accordance with medical staff bylaws, and who is immediately available for overseeing the administration and monitoring of anesthesia by anesthesia personnel. "Immediately available" means that the supervising physician is present in the facility and is available to respond and proceed immediately to the anesthetizing location.

8:43A-12.3 Surgical and anesthesia staff: qualifications

(a)-(b) (No change.)

(c) There shall be a physician director of anesthesia services who is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before *[1972]* ***1982***. The medical director of the facility may serve as physician director of anesthesia services, if the medical director possesses the qualifications of a physician director of anesthesia services as specified in this subsection.

1. Facilities in which conscious sedation only is administered may, in lieu of appointing a director of anesthesia services as specified in (a) above, ensure that each of the physicians who administer, supervise, or monitor the administration of conscious sedation in the facility is credentialed by an acute care hospital, licensed in New Jersey in accordance with N.J.A.C. 8:43G, to administer, supervise, and monitor the administration of conscious sedation.

(d)-(g) (No change.)

(h) The supervision of any anesthesia, except those agents utilized for conscious sedation or minor conduction blocks, shall be provided by a physician who is credentialed in accordance with medical staff bylaws and who is immediately available. The supervising physician may concurrently be responsible for patient care if he or she is available to attend to supervisory duties without jeopardizing the life or safety of patients under his or her care. While supervising anesthesia personnel, the supervising physician shall not perform surgery, except minor surgery as defined by medical staff policy, or administer anesthesia to patients under his or her direct care.

(i) (No change.)

(j) The monitoring of patients who have been administered an anesthetic agent for the purpose of creating conscious sedation shall be provided by an individual who is continuously present for the primary purpose of anesthesia monitoring, who is separate from the individual performing the procedure, and who is one of the following:

1. (No change.)

2. Under the supervision of a physician who has been credentialed in accordance with medical staff bylaws to administer or supervise anesthetic agents used for conscious sedation and who is immediately available:

i.-iii. (No change.)

iv. A registered professional nurse who is certified in basic cardiac life support and who has training and experience in the use of monitoring devices; or

3. (No change.)

(k) Minor conduction blocks shall be administered only by the following:

1. (No change.)

2. Under the supervision of a physician who has been credentialed in accordance with medical staff bylaws to administer or supervise minor conduction blocks and who is immediately available:

1. (No change.)

2. A registered nurse anesthetist who is a qualified candidate for certification under a program governed or approved by the AANA, provided that no national examination for such certification has been administered since the nurse became a qualified candidate for certification;

iii. (No change.)

iv. A certified nurse midwife, a physician assistant, or a nurse practitioner, as permitted by the scope of practice rules of the New Jersey State Board of Medical Examiners and the New Jersey State Board of Nursing, as applicable; or

3. (No change.)

(l) Minor conduction blocks shall be monitored continuously by licensed medical or licensed nursing personnel.

(m) (No change.)

(n) A facility providing surgical services shall have a registered professional nurse other than the director of nursing services to serve as circulating nurse. There shall also be at least one registered professional nurse other than the director of nursing services present whenever a patient is in the postanesthesia care unit. (One person may satisfy both of these requirements if there is no patient in the operating room or no patient in the postanesthesia care unit.)

8:43A-12.4 Policies and procedures

(a) The facility shall develop and implement written bylaws, rules, regulations, policies, and procedures for surgical and anesthesia services, in accordance with the governing authority and medical staff bylaws. The policies and procedures shall be reviewed annually and revised as needed, and shall include at least the following:

1.-10. (No change.)

11. Methods to ensure that gross and microscopic tissue removed surgically or by any other procedure, including termination of pregnancy in accordance with the regulations of the New Jersey State Board of Medical Examiners, N.J.A.C. 13:35-4.2, is examined by a pathologist and a report of the findings is documented in the patient's medical record;

i. The facility shall ensure that the tissue is disposed of in accordance with N.J.A.C. 8:43A-147 of this chapter whether it is examined on the facility's premises or off the facility's premises;

12. (No change.)

13. Requirements for written documentation of surgical procedures performed, including at least a description of the findings, procedures used, specimens removed, patient's condition, any unusual events occurring during the procedure, postoperative diagnosis, and names of the surgeon and assistants. This operative note shall be written or dictated immediately following the procedure by the person performing the surgery and incorporated into the patient's medical record;

14. Policies and procedures for the provision of written instructions to the patient (multilingual, if indicated) on pre- and postsurgical care, including, but not limited to, restrictions on food and beverages before surgery and procedures for obtaining help in the event of surgical wound infection or other postoperative problems;

15. Policies and procedures regarding infection prevention and control, including, but not limited to, the following:

i. Designation of a person with training or experience in surveillance, prevention, and control of nosocomial infection who shall be responsible for the direction, provision, and quality of infection prevention and control services;

ii. Use of aseptic technique and scrub procedures;

iii. Gowning and operating room attire, including changing of masks between procedures;

iv. Traffic control;

v. Cleaning of the operating room after each procedure; and

vi. Care of operating room equipment and anesthesia equipment; and

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16. Procedures for a systematic review and evaluation of patient care and surgical and anesthesia practices and techniques, as part of the quality assurance program of the facility.

i. (No change.)

ii. Quality assurance activities shall include at least the monitoring of outcomes for patients receiving anesthetic agents and postdischarge follow-up of surgical procedures.

iii. (No change.)

8:43A-12.5 Records

(a) (No change.)

(b) A preanesthesia note, reflecting evaluation of the patient and of the patient record prior to administration of anesthesia, shall be made or reviewed by the physician administering or supervising the administration of anesthesia and entered into the medical record of each patient receiving anesthesia at any anesthetizing location.

(c) (No change.)

(d) Postanesthesia notes shall be entered into the patient's medical record early in the postoperative period by a member of the facility's anesthesia team and after the patient's discharge from the postanesthesia care unit by a member of the postanesthesia care unit staff.

(e) The patient's medical record shall include a pathologist's report of gross and microscopic tissue surgically removed.

8:43A-12.6 Surgical service emergency equipment

(a) Emergency equipment available to the operating room in a surgical service shall include at least the following:

1. Emergency call system;
2. Oxygen;
3. Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator;
4. Cardiac defibrillator;
5. Cardiac monitoring equipment;
6. Tracheostomy set;
7. Laryngoscopes and endotracheal tubes;
8. Suction equipment with catheter tip; and
9. Emergency drugs and supplies specified by the medical staff in the facility's policies and procedures.

8:43A-12.7 Anesthesia supplies and equipment; safety systems

(a)-(i) (No change.)

(j) There shall be a written policy to ensure that surgery does not proceed when there are disabled alarms, depleted batteries and inactive sensors in oxygen monitors, improperly positioned breathing-circuit sensors, or other insufficiencies.

8:43A-12.8 Anesthesia supplies and equipment; maintenance and inspection

(a)-(b) (No change.)

(c) All anesthesia equipment shall be inspected before each use. A record of each inspection shall be included in the patient's anesthesia record. Each record may consist of a single phrase or check mark in a box on a form.

8:43A-12.9 Anesthesia supplies and equipment; patient monitoring

(a)-(d) (No change.)

(e) End-tidal carbon dioxide monitoring shall be performed continously during administration of all general anesthesia to intubated patients, unless such monitoring is not clinically feasible for the patient.

(f)-(i) (No change.)

8:43A-12.10 (No change in text.)

8:43A-12.11 Postanesthesia care policies and procedures

(a) (No change.)

(b) The postanesthesia care unit shall have written policies and procedures which are reviewed annually, revised as needed, and implemented. These shall include at least:

1.-7. (No change.)

8. A requirement that patients who receive anesthesia, excluding minor conduction blocks, not drive themselves home after discharge and that they be accompanied home by another person who accepts responsibility for the patient. If the patient fails to comply with the requirement, the circumstances shall be documented in the patient's medical record.

Recodify existing 8:43A-12.11 and 12.12 as 12.12 and 12.13 (No change in text.)

8:43A-12.14 Postanesthesia care patient services

(a)-(f) (No change.)

(g) The postanesthesia care unit shall have immediate access to end-tidal carbon dioxide monitoring, if general anesthesia is administered to intubated patients in the facility.

(h)-(i) (No change.)

(j) Patients shall be discharged from the postanesthesia care unit using discharge criteria, including authority to discharge, which have been developed through the postanesthesia policies and procedures specified at N.J.A.C. 8:43A-*[12.10(b)]****12.11(b)***.

8:43A-12.15 Postanesthesia care units and equipment

(a)-(c) (No change.)

(d) Equipment and services available in the postanesthesia care unit shall include at least emergency equipment and drugs, pulse oximetry, electrocardiographic monitoring, body temperature monitoring, equipment necessary for intubation and extubation, respirometer, various means of oxygen delivery, constant and intermittent suction, blood pressure monitoring, adjustable lighting, peripheral nerve stimulator, equipment which ensures protection of the patient's privacy, and immediate access to a ventilator and to end-tidal carbon dioxide monitoring in accordance with N.J.A.C. 8:43A-12.14(g).

1. (No change.)

(e) (No change.)

8:43A-12.16 Designation of consultant pharmacist

If an ambulatory surgical facility does not have an institutional pharmacy, the facility shall designate a consultant pharmacist who shall review all facility policies and procedures concerning the administration, control, and storage of medications at least semiannually. The consultant pharmacist shall not be affiliated with the pharmacy which provides pharmaceutical services for the facility.

8:43A-12.17 Physical plant

(a) New ambulatory surgical facilities shall comply with Chapter 9, Sections 9.1 and 9.2, and with Chapter 9, Section 9.5, Outpatient Surgical Facility, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, *[1987]* ***1992-1993*** edition, as amended, incorporated herein by reference. (American Institute of Architects-Press, 1735 New York Ave., NW, Washington, D.C. 20006)

(b) When the ambulatory surgical facility is part of an acute care hospital's surgical suite, support services may be shared to avoid duplication. When inpatients and outpatients are served in the same suite, the functional program shall describe in detail scheduling and techniques used to separate inpatients from outpatients.

8:43A-12.18 Exceptions for local anesthesia

Facilities in which local anesthesia or minor conduction blocks only are administered are exempt from complying with the requirements for anesthesia services in this subchapter, except that such facilities shall comply with the following: N.J.A.C. 8:43A-12.1, 12.3(e), 12.3(k), 12.3(l), 12.4(a)1, 12.4(a)2, 12.4(a)4, and 12.4(a)6. The facility shall also comply with N.J.A.C. 8:43A-12.9(g), except that the frequency of determining and charting blood pressure, pulse rate, and respirations may be determined by the facility and specified in the policies and procedures of the facility.

SUBCHAPTER 13. MEDICAL RECORDS

8:43A-13.1 Maintenance of medical records

(a) A current, complete medical record shall be established and maintained for each patient and shall contain documentation of all services provided.

(b) Written objectives, policies and procedures, an organizational plan, and a quality assurance program for medical record services

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shall be developed and implemented. All medical records policies and procedures shall be reviewed at least annually.

(c) Original medical records or components of medical records shall not leave facility premises unless they are under court order or subpoena or removed in order to safeguard the record in the case of a physical plant emergency or natural disaster. Off-site storage of records may be used only *[with the approval of]* ***if*** the Department ***is given prior notice, including the details of the storage arrangement,*** and only if such storage arrangements will ensure retrieval and delivery of the patient's medical record to the facility within one *[hour]* ***business day*** on a seven day per week, 24 hour per day, basis and immediate availability of medical record information through telephone and facsimile communications systems.

(d) A record system shall be maintained in which the patient's complete medical record is filed as one unit, and there shall be a system of access and identification for the medical records of all patients.

8:43A-13.2 Assignment of responsibility

An employee shall be designated to act as coordinator of medical record services. The facility shall designate an employee to act in the absence of the coordinator to ensure staff access to the medical record at all times during the hours of operation.

8:43A-13.3 Contents of medical records

(a) The complete medical record shall include, but not be limited to, the following:

1. Patient identification data, including name, date of admission, address, date of birth, race, religion (optional), sex, and the name, address, and telephone number of the person(s) to be notified in an emergency;

2. The patient's complaint or purpose of the visit;

3. The diagnosis or medical impressions;

4. Orders for laboratory, radiological, diagnostic, and/or screening tests and their results;

5. All orders for treatment, medication, and diets, signed by the prescriber;

6. Documentation of the medical history and physical examination, if performed, signed and dated by the examiner;

7. Patient assessments developed by each service providing care to the patient;

8. A patient plan of care, in accordance with the facility's policies and procedures;

9. Clinical notes, which shall be entered on the day service is rendered;

10. A medication sheet indicating at least the name, date, dosage, and duration of all medications prescribed;

11. A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the person who administered the drug;

12. Documentation of drug allergies in the medical record and on its outside front cover and documentation of other allergies in the medical record;

13. An immunization record, in accordance with the facility's policies and procedures;

14. A record of referrals to or from other health care providers;

15. Documentation of any consultations ordered or provided;

16. Documentation that informed consent was obtained for any procedure or treatment provided which is specified in the facility's policies and procedures as requiring informed consent;

17. Documentation regarding an advance directive, if applicable;

18. The patient's signed acknowledgement that the patient has been informed of patient rights, either verbally or through written copy, and has been offered a copy;

19. Instructions given to the patient and/or family for follow-up care;

20. A record of any treatment, drug, or service offered by personnel of the facility and refused by the patient;

21. The discharge plan, where applicable, and a discharge summary sheet containing the patient's name, address, dates of admission and discharge, and a summary of the treatment and medication rendered during the patient's stay; and

22. Any authorizations granted by the patient for release of the patient's medical record.

8:43A-13.4 Requirements for entries

(a) All orders for patient care shall be prescribed in writing and signed and dated by the prescriber, in accordance with the laws of the State of New Jersey. All orders, including verbal orders, shall be verified or countersigned in writing within seven days.

(b) All entries in the medical record shall be typewritten or written legibly in ink, dated, and signed by the person entering them, or, if a computerized medical records system is used, authenticated.

1. If computer-generated orders with a physician's electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer-generated signature.

2. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:

i. The physician shall sign the original order, history and/or examination at an off-site location;

ii. The original shall be transmitted by FAX system to the facility for inclusion into the medical record;

iii. The physician shall submit the original for inclusion into the medical record within seven days, unless a plain-paper laser facsimile process was used; and

iv. The copy transmitted by FAX system shall be replaced by the original, unless a plain-paper laser facsimile process was used.

(c) The medical record shall be completed within the time frame specified in the medical records policies and procedures, which shall be no longer than 30 days from the last treatment or discharge.

(d) The medical record shall be available to the facility's health care practitioners involved in the patient's care at all times during the hours of operation.

8:43A-13.5 Medical records policies and procedures

(a) The facility shall establish and implement written policies and procedures regarding medical records including, but not limited to, policies and procedures for the following:

1. The protection of medical record information against loss, tampering, alteration, destruction, or unauthorized use. The patient's written consent shall be obtained for release of medical record information;

2. The specific period of time, not to exceed 30 days, within which the medical record shall be completed following treatment or discharge; and

3. The transfer of patient information when the patient is transferred to another health care facility, or if the patient has been an inpatient and becomes an outpatient at the same facility, to ensure continuity of care.

(b) A patient, the patient's legally authorized representative, or a third party insurer where permitted by law may request or authorize, in writing, that a copy of the patient's medical record be provided to one of them or released to a third party. The ambulatory care facility or its subcontractor shall furnish a legible, written copy of the record at a fee based on actual costs. ("Legally authorized representative" within this section means spouse, immediate next of kin, legal guardian, executor, or an individual with power of attorney.) A copy of the medical record from an individual admission shall be provided within 30 days of request, in accordance with the following:

1. The fee for copying records shall not exceed $1.00 per page or $100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than $0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of $200.00 for the entire record;

2. In addition to per page costs, the following charges are permitted:

i. A search fee of no more than $10.00 per patient per request; and

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ii. A postage charge of actual costs for mailing, not to exceed $5.00;

3. No charges shall be assessed other than those permitted in (b)1 and 2 above;

4. The facility shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and

5. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.

(c) The Department shall periodically reevaluate the reasonableness of the fee scale contained in (b) above. ***If the Department determines that a change to the fee scale is warranted, the Department shall propose an amendment to (b) above.***

(d) Access by the patient to the medical record shall be limited only to the extent necessary to protect the patient. A verbal explanation for any denial of access shall be given to the patient or legal guardian by the physician, and there shall be documentation of this in the medical record. In the event that direct access to a copy by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.

8:43A-13.6 Preservation, storage, and retrieval of medical records

(a) All medical records shall be preserved in accordance with N.J.S.A. 26:8-5 et seq.

(b) If the facility plans to cease operation, it shall notify the Department in writing, at least 14 days before cessation of operation, of the location where medical records will be stored and of methods for their retrieval.

SUBCHAPTER 14. INFECTION PREVENTION AND CONTROL SERVICES

8:43A-14.1 Administrator's responsibilities

(a) The administrator shall ensure the development and implementation of an infection prevention and control program.

(b) The administrator shall designate a person with a health care background who shall be responsible for the direction, provision, and quality of infection prevention and control services. The designated person shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, an organizational plan, and a quality assurance program for the infection prevention and control service. If the facility provides primary care, hospital outpatient, ambulatory surgical, or chronic dialysis services, the designated person shall have had training or experience in surveillance, prevention, and control of nosocomial infection.

8:43A-14.2 Infection control policies and procedures

(a) The facility shall establish an infection control committee which shall include the medical director and representatives from at least administration and the nursing service.

(b) The infection control committee, with assistance from each service in the facility, shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following:

1. In accordance with N.J.A.C. 8:57 (*[Chapter II of the State Sanitary Code, Reportable]* ***Communicable*** Diseases), a system for investigating, reporting, and evaluating the occurrence of all infections or diseases which are reportable or conditions which may be related to activities and procedures of the facility;

2. A system for identifying and monitoring nosocomial infections, in conformance with the "CDC Definitions for Nosocomial Infections, 1988" (order number PB 88-187117) incorporated herein by reference;

3. Infection control practices, including universal precautions, in accordance with the Occupational Safety and Health Administration (OSHA) rule 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens, incorporated herein by reference;

4. Control measures or studies to be initiated following identification of an infection control problem;

5. Aseptic technique, employee health in accordance with N.J.A.C. 8:43A-3.7, and staff training.

6. Care of patients with communicable diseases;

7. Exclusion from work, and authorization to return to work, for personnel with communicable diseases;

8. Surveillance techniques to minimize sources and transmission of infection;

9. Sterilization, disinfection, and cleaning practices and techniques used in the facility, including, but not limited to, the following:

i. Care of utensils, instruments, solutions, dressings, articles, and surfaces; and

ii. Selection, storage, use, and disposition of single use and other patient care items; and

10. Collection, handling, storage, decontamination, disinfection, sterilization, and disposal of regulated medical waste and all other solid or liquid waste.

NOTE: Centers for Disease Control publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
or
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Copies of the OSHA rule 29 CFR Part 1910.1030, which was published in the Federal Register on December 6, 1991, can be obtained from:

OSHA Office of Publications
U.S. Department of Labor
Room N3101
200 Constitution Ave., NW
Washington, DC 20210

8:43A-14.3 Infection prevention measures

(a) The facility shall follow all Category I recommendations in the current editions of the following Centers for Disease Control publications, as amended and supplemented, incorporated herein by reference, unless the facility's infection control committee makes a documented exception for a specific guideline:

1. Guideline for Prevention of Catheter-Associated Urinary Tract Infections;

2. Guideline for Prevention of Intravascular Infections;

3. Guideline for Prevention of Surgical Wound Infections;

4. Guideline for Prevention of Nosocomial Pneumonia; and

5. Guideline for Handwashing and Hospital Environmental Control.

(b) The guidelines listed in (a) above may be obtained from the Centers for Disease Control, Atlanta, Georgia 30333, or the sources listed at N.J.A.C. 8:43A-14.2.

8:43A-14.4 Use and sterilization of patient care items

(a) Single use patient care items shall not be reused. Dialyzers may be reused in accordance with N.J.A.C. 8:43A-24.6(f) and the other rules in this chapter. Other patient care items which are reused shall be reprocessed and reused in accordance with manufacturers' recommendations.

(b) Instruments or medical devices which are introduced directly into the bloodstream or into normally sterile areas of the body shall be sterilized.

(c) Instruments or medical devices that come in contact with mucous membranes shall be sterilized or disinfected using high-level disinfection procedures approved by the Environmental Health Services Program of the Department of Health.

(d) All hinged instruments shall be processed in an open position.

(e) Sterilized materials shall be marked with an expiration date and shall not be used after the expiration date.

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(f) Sterilized materials shall be packaged and labeled so as to maintain sterility and so as to permit identification of expiration dates.

(g) Sterilized materials shall be marked with an expiration date not to exceed the time following sterilization recommended by the manufacturer.

8:43A-14.5 Care and use of sterilizers

(a) Sterilizers shall be kept clean.

(b) Sterilizer drains shall be flushed at least weekly, unless otherwise specified by the manufacturer, and a record shall be maintained.

(c) At the completion of each sterilization load, the time, temperature, and pressure readings shall be checked and recorded.

(d) A record of each sterilization load, including the date, the load number, ***and*** the contents of the load *[and the expiration dates of the contents,]* shall be maintained for at least one year.

(e) Biological monitoring with live spores shall be performed on each ethylene oxide sterilizer at least daily and following repair of the sterilizer.

(f) For steam sterilizers used to sterilize instruments, biological monitoring with live spores shall be performed on each sterilizer at least weekly and following repair of the sterilizer.

8:43A-14.6 Regulated medical waste

(a) Regulated medical waste shall be collected, stored, handled, and disposed of in accordance with applicable Federal and State laws and regulations.

(b) The facility shall comply with the provisions of N.J.S.A. 13:1E-48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules promulgated pursuant to the aforementioned act.

8:43A-14.7 Disposition of tissue

All tissue, including gross and microscopic tissue, removed surgically or by any other procedure, including termination of pregnancy in accordance with the rules of the New Jersey State Board of Medical Examiners, N.J.A.C. 13:35-4.2, shall be incinerated, interred in accordance with N.J.S.A. 26:6, or disposed of through the application of an alternative technological process approved specifically for a given case by the New Jersey State Department of Health in consultation with the New Jersey State Department of Environmental Protection.

SUBCHAPTER 15. EMERGENCY SERVICES AND DISASTER PLANS

8:43A-15.1 Disaster planning

(a) The facility shall have written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of potential hazards that could necessitate an evacuation, including internal and external disasters such as fire, natural disaster, bomb threats, or industrial or radiological accidents.

(b) The written, comprehensive emergency plan shall be filed with the Department of Health, and the Department shall be notified when the plan is changed. Copies of emergency plans shall also be forwarded to both municipal and county emergency management officials for their review.

(c) Procedures for emergencies shall include at least:

1. Protocols for notification of emergency service providers and officials;

2. Locations of emergency equipment and alarm signals;

3. Evacuation routes;

4. Procedures for evacuating patients;

5. Identification of one or more facilities to which patients would be referred in the event of extended closure of the facility;

6. Procedures for reentry after evacuation;

7. Tasks and responsibilities assigned to all personnel and identification of the person in the facility designated to coordinate emergency activities;

8. Protocols for removal and return of records, medications, supplies, and equipment after evacuation; and

9. Alternative procedures if patients cannot be returned to the facility.

(d) The facility shall ensure that patients receive necessary services during the evacuation or other emergency.

(e) A written evacuation diagram that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers shall be conspicuously posted throughout the facility.

(f) All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and patient evacuation as part of their initial orientation and at least annually thereafter.

8:43A-15.2 Drills, tests, and inspections

(a) Drills of emergency plans shall be conducted on each shift at least quarterly. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The drills on each shift shall include at least one drill for emergencies due to fire and one drill for emergencies due to disasters other than fire, such as storm, flood, other natural disaster, bomb threat, or radiological accident.

(b) The facility shall perform quarterly tests of the building's manual pull alarm system and shall maintain documentation of test dates, locations of manual pull alarms tested, persons testing the alarms, and results of the tests.

(c) Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' requirements, National Fire Protection Association (N.F.P.A.) 10, as amended and supplemented, and N.J.A.C. 5:18, the New Jersey Uniform Fire Code.

(d) The facility shall request, at least annually, that a fire inspection be performed by the local fire code authority, and the request shall be documented. The date of inspection, the results, and the inspector or agent conducting the inspection shall be documented.

(e) There shall be at least a semiannual inspection of the fire detection system. The date of inspection, the results, and the inspector or agent conducting the inspection shall be documented.

(f) There shall be at least a semiannual inspection of the automatic sprinkler system, if applicable. The date of inspection, the results, and the inspector or agent conducting the inspection shall be documented.

(g) There shall be at least monthly testing of emergency lighting. A logbook shall be maintained which shall include the date of each test, the results, and the person conducting the test.

(h) There shall be an elevator inspection, if applicable, in accordance with N.J.A.C. 5:23-12.3 of the Elevator Safety Subcode. The date of inspection, the results, and the licensed official or inspector conducting the inspection shall be documented.

(i) There shall be at least an annual inspection of the heating and ventilation system. The date of inspection, the results, and the inspector or agent conducting the inspection shall be documented.

(j) The temperature of the hot water used in the facility shall be tested and documented in accordance with the policies and procedures of the facility.

8:43A-15.3 Emergency medical services

(a) The facility shall have written policies and procedures that are reviewed annually, revised as needed, and implemented as needed to meet medical emergencies based on the type of patients and cases that are typically treated at the facility.

(b) The facility shall be able to respond to medical emergencies occurring on the premises during its hours of operation.

(c) Emergency medical services not provided at the facility shall be provided by a hospital or hospitals by written agreement. The facility shall have a written plan for emergency transportation of patients.

(d) The facility shall have written policies and procedures regarding emergency kits and, if required, emergency carts which are appropriate to the patient population served by the facility and approved by the medical director. The policies and procedures shall be reviewed annually, revised as needed, and implemented, and shall:

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1. Specify the locations, contents, frequency of checking contents (including expiration dates), and assignments of responsibility for checking contents; and

2. Ensure that emergency kits are secure but are not kept under lock and key.

(e) At least one person who is trained in the use of emergency equipment shall be available whenever there is a patient in the facility.

SUBCHAPTER 16. PATIENT RIGHTS

8:43A-16.1 Policies and procedures

(a) The facility shall establish and implement written policies and procedures regarding the rights of patients. These policies and procedures shall be available to patients, staff, and the public and shall be conspicuously posted in the facility.

(b) The staff of the facility shall receive in-service education concerning the implementation of policies and procedures regarding patient rights annually and as part of new employee orientation.

(c) The facility shall comply with all applicable State and Federal statutes and rules concerning patient rights.

8:43A-16.2 Rights of each patient

(a) Each patient receiving services in an ambulatory care facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;

2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;

3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;

4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;

5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;

6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;

7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;

8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;

11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;

12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient; and

13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.

8:43A-16.3 Notice

(a) The administrator shall provide all patients and/or their families upon request with the name, addresses, and telephone numbers of the following offices where complaints may be lodged:

Division of Health Facilities
Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625-0367
Telephone: (609) 792-9770
and
State of New Jersey
Office of the Ombudsman for the
Institutionalized Elderly
CN 808
Trenton, New Jersey 08625
Telephone: (609) 624-4262

(b) The administrator shall also provide all patients and/or their families upon request with the names, addresses, and telephone numbers of offices where information concerning Medicare and Medicaid coverage may be obtained.

(c) Addresses and telephone numbers contained in (a) and (b) above shall be conspicuously posted throughout the facility, including, but not limited to, the admissions waiting area or room, the patient service area of the business office, and other public areas.

SUBCHAPTER 17. HOUSEKEEPING, SANITATION AND SAFETY

8:43A-17.1 Provision of services

(a) The facility shall provide and maintain a sanitary and safe environment for patients.

(b) The facility shall provide housekeeping, laundry, and pest control services.

(c) Written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for housekeeping, sanitation, and safety services shall be developed and implemented.

(d) The facility shall perform a documented review of housekeeping, sanitation, and safety services at least annually.

8:43A-17.2 Housekeeping

(a) A written work plan for housekeeping operations shall be established and implemented, with categorization of cleaning assign-

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ments as daily, weekly, monthly, or annually within each area of the facility.

(b) Housekeeping personnel shall be trained in cleaning procedures, including the use, cleaning, and care of equipment.

8:43A-17.3 Patient care environment

(a) The following housekeeping and sanitation conditions shall be met:

1. The facility and its contents shall be clean to sight and touch and free of dirt and debris;

2. All rooms shall be free of condensation, mold growth, and noxious odors;

3. All equipment and materials necessary for cleaning, disinfecting, and sterilizing (if applicable) shall be provided;

4. Thermometers which are accurate to within three degrees Fahrenheit shall be kept in a visible location in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration;

5. Articles in storage shall be elevated from the floor and away from walls, ceilings, and air vents;

6. Unobstructed aisles shall be provided in storage areas;

7. Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility. The premises shall be kept in such condition as to prevent the breeding, harborage, or feeding of vermin. All openings to the outer air shall be effectively protected against the entrance of insects;

8. Toilet tissue, soap, and disposable towels or air driers shall be provided in each bathroom at all times. Soap and disposable towels or air driers shall be provided at each handwashing sink at all times;

9. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof;

10. Latex foam pillows shall be prohibited;

11. Equipment requiring drainage shall be drained to a sanitary connection, in accordance with State and local codes;

12. During warm weather conditions, the temperature of the facility shall not exceed 82 degrees Fahrenheit. The facility shall establish a written heat emergency action plan which specifies procedures to be followed in the event that the indoor air temperature is 82 degrees Fahrenheit or higher for a continuous period of four hours or longer. The facility shall provide adequate ventilation in all areas used by patients; and

3. The temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) when patients are in the facility.

(b) The following safety conditions shall be met:

1. Nonskid wax shall be used on all waxed floors;

2. Throw rugs or scatter rugs shall not be used in the facility;

3. All equipment shall have unobstructed space provided for operation;

4. Pesticides shall be applied in accordance with State Pesticide Control Regulations, N.J.A.C. 7:30;

5. All household and cleaning products in the facility shall be identified, labeled, and securely stored in a cabinet, closet, or room which is inaccessible to patients;

6. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement;

7. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored outside the building. Minimum supplies may be kept in the building in a locked storage room or in closed, locked metal cabinets or containers in a non-patient area of the facility; and

8. All furnishings shall be clean and in good repair, and mechanical equipment shall be in good working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly.

8:43A-17.4 Waste removal

(a) All solid or liquid waste which is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health. Solid waste shall be stored in insectproof, rodentproof, fireproof, nonabsorbent, watertight containers with tightfitting covers and collected from storage areas regularly so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24.

(b) If garbage compactors are used, their installation and use shall be in compliance with all State and local codes.

8:43A-17.5 Water supply

(a) The water supply used for drinking or culinary purposes shall be adequate in quantity, of a safe and sanitary quality, and from a water system which shall be constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq., N.J.A.C. 7:10, and local laws, ordinances, and regulations. There shall be no back siphonage conditions present. Copies of the Safe Drinking Water Act can be obtained from the Department of Environmental Protection, Bureau of Potable Water, CN 209, Trenton, New Jersey 08625.

(b) The temperature of the hot water used for handwashing shall be maintained between 95 degrees and 120 degrees Fahrenheit (35 to 49 degrees Celsius). If the facility provides the means for patient bathing, the temperature of the hot water used for patient bathing shall be maintained between 95 degrees and 110 degrees Fahrenheit (35 to 43 degrees Celsius).

(c) The sewage disposal system shall be maintained in good repair and operated in compliance with State and local laws, ordinances, rules and regulations.

8:43A-17.6 Laundry services

(a) If laundry services are provided, written policies and procedures shall be established and implemented for the facility's laundry services, including, but not limited to, policies and procedures for the following:

1. The provision of clean laundry for each patient, including blankets, if required. Linen shall be changed between each instance of patient use;

2. Collection of soiled laundry so as to avoid microbial dissemination into the environment, and placement in impervious bags or containers that are closed at the site and time of collection. Containers shall be in good repair, kept clean, and identified for use with either clean or soiled laundry;

3. Protection of clean laundry from contamination during processing, transporting, and storage; and

4. The sanitizing of equipment surfaces that come into contact with laundry.

(b) Soiled laundry shall be stored in a ventilated area separate from any other supplies. Soiled laundry shall not be stored, sorted, rinsed, or laundered in patient areas, bathrooms, areas of food preparation and/or storage, or areas in which clean laundry and/or equipment are stored.

(c) If the facility has an in-house laundry, written policies and procedures shall be followed to reduce the number of bacteria in the fabrics during laundering. There shall be a receiving, holding, and sorting area with handwashing facilities accessible to the area. The walls, floors, and ceilings of the area shall be clean and in good repair. Ventilation shall be adequate to prevent heat and odor buildup.

SUBCHAPTER 18. QUALITY ASSURANCE PROGRAM

8:43A-18.1 Quality assurance plan

(a) The facility shall establish and implement a written plan for a quality assurance program for patient care. The quality assurance plan shall be reviewed at least annually and revised as necessary. The plan shall specify a timetable and the individual responsible for coordinating the quality assurance program and shall provide for ongoing monitoring of staff and patient care services.

(b) There shall be a multidisciplinary committee responsible for the direction of the quality assurance program. The committee shall include at least representation from the medical staff, nursing staff

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and administration. The committee shall establish a mechanism to include participation of all disciplines in the identification of areas for review that affect patient care throughout the facility.

8:43A-18.2 Quality assurance activities

(a) There shall be an ongoing process for monitoring and evaluating patient care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, patient care statistics, and discharge planning services.

(b) Evaluation of patient care throughout the facility shall be criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

(c) The quality assurance process shall incorporate periodic review of patient medical records.

(d) The quality assurance process shall include evaluation by patients of care and services provided by the facility. If the families of patients are routinely involved in the care and services provided by the facility, the quality assurance process shall include a means for obtaining input from families of patients.

(e) The administrator shall follow up on the findings of the quality assurance program to ensure that effective corrective actions have been taken, including at least policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

(f) The quality assurance program shall identify and establish indicators of quality care specific to the facility, which shall be monitored and evaluated.

(g) The results of the quality assurance program shall be submitted to the governing authority at least annually and shall include at least deficiencies found and recommendations for corrections or improvements. Deficiencies which jeopardize patient safety shall be reported to the governing authority immediately.

SUBCHAPTER 19. PHYSICAL PLANT AND FUNCTIONAL REQUIREMENTS

8:43A-19.1 Physical plant general compliance for new construction or alteration

(a) New buildings and alterations and additions to existing buildings for freestanding ambulatory care facilities shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23-3.2, subchapters of the current model code of the Building Officials and Code Administrators International (BOCA), Inc. (4051 W. Flossmoor Road, Country Club Hills, IL 60477-5795), appropriate to Use Group B, as amended and supplemented, and the current edition of the Guidelines for Construction and Equipment of Hospital and Medical Facilities (The American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006 ***)***, as amended and supplemented, incorporated herein by reference.

(b) New buildings and alterations and additions to existing buildings for ambulatory care facilities which are part of an acute care hospital shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23-3.2, subchapters of the current model code of the Building Officials and Code Administrators International (BOCA), Inc. (4051 W. Flossmoor Road, Country Club Hills, IL 60477-5795), appropriate to Use Group I-2, as amended and supplemented, and the current edition of the Guidelines for Construction and Equipment of Hospital and Medical Facilities (The American Institute of Architect Press, 1735 New York Ave., NW, Washington, D.C. 20006), as amended and supplemented, incorporated herein by reference.

8:43A-19.2 Physical plant general compliance for construction or alteration completed prior to the effective date of this chapter

Existing buildings constructed or altered prior to the effective date of this chapter shall be in conformance with Federal, State, and local standards in effect at the time of construction, alteration, or approval of plans by the Department.

8:43A-19.3 Plan review fees

(a) Prior to any construction, plans shall be submitted for review and approval, in accordance with the provisions of this chapter, to:

Health Facilities Construction Services
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625

(b) Review fees shall be paid, pursuant to N.J.A.C. 8:31-1.1.

8:43A-19.4 Alterations and repairs

(a) If alterations or repairs costing in excess of 50 percent of the physical value of the structure are made within any period of 12 months, requirements for new structures shall apply to the entire structure, including those portions not altered or repaired.

(b) If alterations or repairs costing between 25 percent and 50 percent of the physical value of the structure are made within any period of 12 months, only the altered or repaired portions need to conform to the requirements for new structures.

(c) If alterations or repairs costing under 25 percent of the physical value of the structure are made within any period of 12 months, the construction official and appropriate subcode officials shall determine to what degree the portions so altered or repaired shall be made to conform to the requirements for new structures.

8:43A-19.5 Provision for the handicapped

Facilities shall be available and accessible to the physically handicapped pursuant to the New Jersey Uniform Construction Code, N.J.A.C. 5:23-7, Barrier-Free Subcode, and P.L. 100-336, the Americans with Disabilities Act of 1990 and Accessibility Guidelines for Buildings and Facilities, as amended and supplemented, incorporated herein by reference. (Available from the Government Printing Office, Superintendent of Documents, Washington, D.C. 20402.)

8:43A-19.6 Common elements for ambulatory health care facilities

All new ambulatory health care facilities***, except small facilities addressed at N.J.A.C. 8:43A-19.7,*** shall comply with Chapter 9, Section 9.2, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, *[1987]* ***1992-1993*** edition, as amended, and other sections appropriate to the specific service(s) provided therein, all of which is incorporated herein by reference.

8:43A-19.7 Small ambulatory care facilities

Chapter 9, Section 9.4, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, *[1987]* ***1992-1993*** edition, as amended, is incorporated by reference herein and shall apply to new small ambulatory care facilities. "Small ambulatory care facility" means a facility which provides ambulatory care services and in which the space and equipment are utilized by four or fewer workers at any one time.

SUBCHAPTER 20. FAMILY PRACTICE SERVICES

8:43A-20.1 Additional requirements

An ambulatory care facility which provides family practice services shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter.

8:43A-20.2 Medical staff to be provided

If an ambulatory care facility provides family practice services, the medical director shall be a family practice physician or the facility shall have a family practice physician on the medical staff. The family practice physician shall be available during the facility's hours of operation. ("Available" means capable of being reached.)

SUBCHAPTER 21. FAMILY PLANNING, PRENATAL, POSTPARTUM, AND GYNECOLOGICAL SERVICES

8:43A-21.1 Additional requirements and exceptions

(a) An ambulatory care facility which provides family planning, prenatal, postpartum, and/or gynecological services shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter.

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If the facility also provides surgical or anesthesia services, then the facility shall also comply with N.J.A.C. 8:43A-12.

1. An ambulatory care facility which provides only family planning services need not comply with N.J.A.C. 8:43A-2.2(b) for the purpose of licensure.

2. The facility shall be a formal member of a Maternal and Child Health Consortium, in accordance with N.J.A.C. 8:33C.

8:43A-21.2 Application for licensure

The Department shall charge a nonrefundable fee of $100.00 for the filing of an application for licensure of an ambulatory care facility which provides, primarily or solely, family planning services and for the annual renewal of the license. The corresponding fee for each satellite of the facility which also provides, primarily or solely, family planning services shall be $100.00. If such a facility or satellite provides a service listed in N.J.A.C. 8:43A-2.3(a) as an additional, secondary service, the facility or satellite shall submit an additional nonrefundable fee of $250.00 per additional service for the filing of the application for licensure and for the annual renewal of the license.

8:43A-21.3 Medical staff to be provided

If an ambulatory care facility provides prenatal, postpartum, gynecological, and/or family planning services, the medical director shall be an obstetrician-gynecologist or the facility shall have an obstetrician-gynecologist on the medical staff. The obstetrician-gynecologist shall be available during the facility's hours of operation. ("Available" means capable of being reached.)

8:43A-21.4 Medical history

In addition to complying with N.J.A.C. 8:43A-6.4(a), the facility shall obtain the patient's obstetrical and gynecological history, if appropriate, including a history of psychological and social problems.

8:43A-21.5 Medical records

(a) The complete medical record for prenatal patients shall include, but not be limited to, documentation of assessment of uterine growth, fetal heart tones, estimated delivery date, urine tests for protein, blood pressure, weight gain, and an updated assessment of obstetrical risk***, and shall be in conformance with N.J.A.C. 8:33C-4.3***.

(b) The facility shall establish and implement written policies and procedures regarding the transfer of patient information when the patient is transferred to another health care facility, or if the patient has been an inpatient and becomes an outpatient at the same facility, to ensure continuity of care. In the case of a prenatal patient, a copy or summary of the patient's prenatal medical record shall be transferred, no later than 34 weeks gestation, from the facility to the inpatient facility where delivery is to take place. The facility shall also request a copy or summary of the patient's labor, delivery and postpartum record from the inpatient facility prior to any scheduled postpartum visits.

SUBCHAPTER 22. PEDIATRIC SERVICES

8:43A-22.1 Additional requirements

(a) An ambulatory care facility which provides pediatric services shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter.

1. The facility shall be a formal member of a Maternal and Child Health Consortium, in accordance with N.J.A.C. 8:33C.

8:43A-22.2 Medical staff to be provided

A facility which provides pediatric services shall have a pediatrician or family practice physician on the medical staff and available during the facility's hours of operation. ("Available" means capable of being reached.)

8:43A-22.3 Medical records

The complete medical record for pediatric patients shall include, but not be limited to, documentation of assessment of growth, including at least a record of weight and length or height, documentation of a basic developmental assessment, including sensory screenings, and a record of immunization.

SUBCHAPTER 23. PRIMARY CARE

8:43A-23.1 Additional requirements

(a) An ambulatory care facility which provides primary care services, as defined at N.J.A.C. 8:43A-1.3, shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this suchapter. If the facility provides family practice services, then the facility shall also comply with the rules in N.J.A.C. 8:43A-20. If the facility provides primary care to a pediatric population, then the facility shall also comply with the rules in N.J.A.C. 8:43A-22.

1. If a facility provides primary care services only, the requirement at N.J.A.C. 8:43A-8.2 for a registered professional nurse to be on the premises during the hours of operation may be satisfied by a physician, if permitted by the policies and procedures of the facility.

8:43A-23.2 Infection prevention and control

The administrator shall designate a person with training or experience in surveillance, prevention, and control of nosocomial infection who shall be responsible for the direction, provision, and quality of infection prevention and control services.

8:43A-23.3 Mobile vans

(a) If a facility wishes to provide services through use of one or more mobile vans, the facility shall obtain the prior authorization of the Licensing, Certification and Standards Program of the Department. Such authorization may be contingent upon an on-site inspection by representatives of the Department.

(b) Policies and procedures for the use of mobile vans in the provision of primary care services shall address at least patient care, control of drugs, medical records, and infection prevention and control.

8:43A-23.4 Freestanding primary care outpatient facilities

New freestanding facilities which provide primary care services***, except small facilities addressed at N.J.A.C. 8:43A-23.5,*** shall comply with Chapter 9, Sections 9.1, 9.2, and 9.3, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, *[1987]* ***1992-1993*** edition, as amended, incorporated herein by reference.

8:43A-23.5 Small primary care outpatient facilities

(a) Small primary care outpatient facilities may be located within existing commercial, residential, licensed child care, educational, or other types of buildings or may be small, freestanding, new or converted structures. "Small primary care outpatient facility" means a facility which provides primary care services and in which the space and equipment are utilized by four or fewer workers at any one time.

(b) New small primary care outpatient facilities shall comply with Chapter 9, *[Sections 9.1, 9.2, 9.3, and]* ***Section*** 9.4, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, *[1987]* ***1992-1993*** edition, as amended, incorporated herein by reference.

SUBCHAPTER 24. CHRONIC DIALYSIS SERVICES

8:43A-24.1 Additional requirements

Hospital facilities which provide renal dialysis services within the hospital shall comply with N.J.A.C. 8:43G-30. All other ambulatory care facilities which provide chronic dialysis services shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter.

8:43A-24.2 Minimum program size and transfer agreements

(a) A facility providing chronic dialysis services shall have at least nine *[machines/]*stations. Facilities licensed prior to the effective date of this chapter shall have until January 1, 1994, to establish this minimum number of *[machines/]*stations. *[An]* ***In the case of new construction or renovation involving at least 25 percent of the physical plant, an*** open treatment area shall contain no more than 20 *[machines/]*stations.

(b) A facility providing chronic dialysis services shall have a written transfer agreement with at least one hospital-based chronic dialysis unit with acute dialysis capacity and with at least one facility having a renal transplantation program.

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8:43A-24.3 Patient services

(a) The facility's policy on dialyzer reuse shall be explained to all chronic dialysis patients, and the facility shall document each patient's decision regarding consent to dialyzer reuse. If the patient declines reuse, arrangements shall be made for the patient to receive single-use treatment in the facility.

(b) In addition to complying with N.J.A.C. 8:43A-6.4, the facility shall ensure that a medical history is obtained and a physical examination is performed for each chronic dialysis patient within seven days of initiation of treatment and that these are updated at least every five years.

(c) A written plan of care shall be developed for each chronic dialysis patient by a multidisciplinary team which includes, at least, a nephrologist, a transplant surgeon or designee, a registered professional nurse, a dietitian, and a licensed social worker or a social worker hired prior to 1976 who receives consultation from a licensed social worker. The plan of care shall specify goals and expected outcomes.

(d) The written plan of care for each chronic dialysis patient shall be discussed with the patient and/or family, implemented within four weeks of admission to the facility, reviewed by the multidisciplinary team at least every six months, and revised as needed.

(e) Each member of the multidisciplinary team shall enter clinical notes into the chronic dialysis patient's medical record.

(f) If a chronic dialysis patient is referred by, or transferred from, another health care facility, the facility providing chronic dialysis services shall provide the referring or transferring facility with copies of summaries of the patient's progress, a description of dietary care, and results of laboratory tests upon discharge from the facility providing chronic dialysis services or upon request.

(g) Chronic dialysis patients shall be dialyzed in chairs which can be inclined so that the patient's head is lower than his or her feet, except when the patient is dialyzed in a hospital bed.

8:43A-24.4 Qualifications of the medical director and medical records coordinator

(a) The medical director of a facility which provides chronic dialysis services shall be a nephrologist. A medical director designated prior to July 1, 1993, shall have the qualifications of a nephrologist as specified at N.J.A.C. 8:43A-1.15. A medical director designated on or after July 1, 1993, shall be a diplomate of either the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine in the subspecialty of nephrology.

(b) The coordinator of medical records designated in accordance with N.J.A.C. 8:43A-13.2 shall be a medical records practitioner or shall function in consultation with a person so qualified. The medical records practitioner shall:

1. Be certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association (875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611); or

2. Be a graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Records Association.

8:43A-24.5 Nurse staffing

(a) A facility providing chronic dialysis services shall have at least one registered professional nurse, licensed practical nurse, or trained technician on duty for every three patients receiving dialysis services on the premises. In all cases, there shall be at least one registered professional nurse on duty for *[every]* ***the first*** nine patients receiving dialysis services on the premises ***and an additional registered professional nurse if the number of patients exceeds nine***, including the registered professional nurse required by N.J.A.C. 8:43A-8.2.

(b) Members of the nursing staff of facilities which provide chronic dialysis services shall receive on-site training in renal dialysis techniques, as determined by the facility, before they are permitted to work without direct supervision.

(c) If home (self) care dialysis training services are provided, a registered professional nurse shall direct the home (self) care dialysis training program. Training of patients may be assigned to licensed practical nurses. In no case shall training be conducted by less than one licensed nurse for every two patients on the premises receiving home (self) care dialysis training.

(d) If self care dialysis services are provided on the premises, there shall be a minimum of one licensed nurse on duty for every six patients on the premises receiving self care dialysis.

(e) If pediatric dialysis services are provided, there shall be a minimum of two registered professional nurses, licensed practical nurses, or trained technicians on duty for every three patients receiving chronic pediatric dialysis services on the premises. There shall be a minimum of one registered professional nurse in the pediatric dialysis service whenever services are being provided. The registered professional nurse may be considered as one of the total number of required nursing service staff members.

(f) If an administrator performs both administrative and other functions, written documentation of the administrator's time spent in each function shall be maintained. The administrator's time spent in administrative functions shall not be included in the computation of staffing levels for nursing services.

8:43A-24.6 Infection prevention and control

(a) The administrator shall designate a person with training or experience in surveillance, prevention, and control of nosocomial infection who shall be responsible for the direction, provision, and quality of infection prevention and control services.

(b) The facility shall have written infection control policies and procedures specific to the chronic dialysis service, which shall include universal precautions.

(c) All staff members of the chronic dialysis service and all chronic dialysis patients shall be screened for hepatitis in accordance with the current edition of the Centers for Disease Control publication "Hepatitis Surveillance," as amended and supplemented, available from the Centers for Disease Control, Atlanta, Georgia 30333, incorporated herein by reference.

(d) Facilities which provide chronic dialysis services shall comply with the Occupational Safety and Health Administration (OSHA) rule 29 CFR Part 1910.1030, incorporated herein by reference, as it pertains to hepatitis B vaccination.

(e) Chronic dialysis patients with communicable or transmittable diseases shall be treated in accordance with Centers for Disease Control guidelines.

(f) If dialyzers are reused, reuse shall conform with guidelines in the Association for the Advancement of Medical Instrumentation (AAMI) publications, "Recommended Practice for Reuse of Hemodialyzers," incorporated herein by reference.

(g) A facility providing chronic dialysis services shall establish and implement policies and procedures regarding cleaning and***/or*** disinfecting of patient reclining chairs, beds (including mattresses) and dialysis machines between each instance of patient use, and daily cleaning and disinfecting of floors and walls in the dialysis area.

(h) Water treatment equipment, water, and dialysate shall satisfy the requirements specified in the Association for the Advancement of Medical Instrumentation (AAMI) publication entitled "American National Standard for Hemodialysis Systems," as amended and supplemented, incorporated herein by reference.

1. Water and dialysate shall be microbiologically analyzed monthly. Water samples shall be taken immediately beyond the last water treatment device and at other locations in each treatment area so as to ensure that water throughout the distribution lines conforms with AAMI standards. Chemical analysis of the water shall be performed every six months.

2. A DPD test kit or similar method shall be used daily to detect the presence of chloramine and to measure chloramine levels in water used to prepare dialysate. The level of chloramine shall not exceed the AAMI standard of 0.1 ppm.

3. Written records of analysis procedures and results and of equipment maintenance shall be maintained in the facility.

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Note: AAMI publications can be obtained from:
Association for the Advancement of Medical Instrumentation
Suite 602
1901 North Fort Meyer Drive
Arlington, VA 22209

(i) All food served to patients in the dialysis service shall be provided in completely disposable food service equipment. The facility shall comply with N.J.A.C. 8:24.

(j) The facility shall have policies and procedures as to whether or not chronic dialysis patients shall be permitted to bring their own food into the dialysis treatment area. If permitted, the facility shall develop a policy regarding the categories of food permitted, food preparation and storage, and utensils to be used.

8:43A-24.7 Home care dialysis services

(a) If home (self) care dialysis services are provided, the facility shall establish, implement, and review, at least annually, written policies and procedures including, but not limited to, policies and procedures for the following:

1. Development of a written outline of the home (self) care training program, including didactic and practical sessions, for the unsupervised performance of dialysis treatments by patients and family;

2. Surveillance of the patient's home adaptation through visitation of the patient's home by a registered professional nurse, including the frequency of home visitation and documentation of the results of surveillance visits in the patient's medical record;

3. Availability of teaching materials for patient use during and after home (self) care dialysis training and at times other than during the dialysis procedure;

4. Provision of consultation to the patient by a social worker and a dietitian;

5. Installation and maintenance of equipment in the home;

6. Testing and treatment of the water in the home; and

7. Ordering of supplies for the home on an ongoing basis.

8:43A-24.8 Quality assurance

If chronic dialysis services are provided, the quality assurance program shall monitor those indicators required by the Trans-Atlantic Renal Council (180 Tices Lane, East Brunswick, NJ 08816) and shall monitor care provided to home dialysis patients.

8:43A-24.9 Patient rights

Each chronic dialysis patient shall be afforded rights in accordance with the principles set out in the Trans-Atlantic Renal Council's Bill of Rights for renal dialysis patients, incorporated herein by reference.

8:43A-24.10 Physical plant requirements for all chronic dialysis facilities

(a) Each *[machine/]*station in the chronic dialysis service shall have a cubicle curtain for privacy. One handwashing sink shall be available for every three *[machines/]*stations. These handwashing sinks shall be distributed throughout the treatment area so as to ensure immediate accessibility to staff at all times.

(b) The gross floor area allocated for each machine shall be at least 100 square feet with a net usable area of at least 80 square feet. There shall be at least 30 inches clear around each machine and lounge, except that one side of the machine may be installed flush against the wall. There shall be at least a four-foot space between beds and/or lounges.

(c) There shall be a separate clean holding area or room within the chronic dialysis suite for storage of clean supplies. If the facility has a clean utility room, then the clean utility room shall contain a minimum of 120 square feet with handwashing facilities.

(d) There shall be a separate soiled utility room within the chronic dialysis suite. The soiled utility room shall contain a minimum of 120 square feet and shall contain a sink equipped for handwashing. The floor of the soiled utility room shall be monolithic with integral base.

(e) A separate janitors' closet shall be provided exclusively for the chronic dialysis suite. The closet shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

(f) A separate, handicapped accessible toilet room with handwashing facilities shall be provided for patients.

(g) A staff lounge/locker room and toilet facilities with handwashing facilities shall be provided.

(h) The nurses' station shall be designed and located so as to permit visual observation of each patient station.

(i) Door(s) to patients' toilet room(s) shall be equipped with hardware which permits access from the exterior by staff in any emergency.

(j) If home training rooms are provided, each room shall be equipped with a sink for handwashing.

(k) Storage space shall be provided for wheelchairs and stretchers, if stretchers are provided, out of direct line of traffic.

(l) A room shall be provided for the storage of equipment used in patient care.

(m) An examination room shall be provided with a minimum of 80 square feet of clear floor area exclusive of the work counter and lavatory for handwashing.

(n) Water supply systems shall be designed to supply water to the fixtures and equipment at a minimum pressure of 15 pounds per square inch during periods when fixtures and equipment are in use.

(o) Office space shall be provided for administration, nursing services, social work services, and dietary counseling services.

(p) Space for conferences, consultation, and other purposes shall be provided.

(q) A waiting area with access to a telephone, toilet facilities, and a drinking fountain shall be provided.

(r) Each toilet facility for patients shall be served by an emergency call system. Calls shall activate a signal at the nurses' station.

(s) There shall be a drug distribution station for the chronic dialysis service. The drug distribution station shall contain handwashing facilities and a work counter. Provisions shall be made for the controlled storage, preparation, and distribution of medications.

(t) If a nourishment station for the chronic dialysis service is provided, the nourishment station shall contain a sink, a work counter, a refrigerator, storage cabinets, and equipment for serving nourishments as required.

SUBCHAPTER 25. COMPUTERIZED TOMOGRAPHY (CT), MAGNETIC RESONANCE IMAGING (MRI), AND RADIOLOGICAL SERVICES

8:43A-25.1 Additional requirements and exceptions

(a) An ambulatory care facility which provides computerized tomography, magnetic resonance imaging, or radiological services shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter. If the facility also provides surgical or anesthesia services, then the facility shall also comply with N.J.A.C. 8:43A-12.

1. An ambulatory care facility which provides only computerized tomography, magnetic resonance imaging, or radiological services need not comply with N.J.A.C. 8:43A-3.6(a)6, 13.3(a)7 and 13.3(a)8 for the purpose of licensure.

2. If the facility provides only ***computerized tomography,*** magnetic resonance imaging***, or radiological*** services, a radiologic technologist may satisfy the requirement for an administrator at N.J.A.C. 8:43A-5.1.

3. If the facility provides only ***computerized tomography,*** magnetic resonance imaging***, or radiological*** services, the part of N.J.A.C. 8:43A-3.1(a) which requires nursing services to be provided in the facility shall not apply***, unless nursing services are ordered by a physician***.

4. If the facility provides only ***computerized tomography,*** magnetic resonance imaging***, or radiological*** services, the part of N.J.A.C. 8:43A-6.2(a) which requires a representative of the nursing staff to serve on the patient care policy committee shall not apply.

5. If the facility provides only ***computerized tomography,*** magnetic resonance imaging***, or radiological*** services, the part of N.J.A.C. 8:43A-18.1(b) which requires a representative of the nurs-

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ing service to serve on the committee responsible for the quality assurance program shall not apply.

6. An ambulatory care facility which provides only computerized tomography, magnetic resonance imaging, or radiological services may satisfy the requirements at N.J.A.C. 8:43A-14.2 for an infection control committee by requiring the person responsible for the infection prevention and control program to ensure that the medical director and other professional staff participate in the development and implementation of the program, including the development, implementation, and review of the policies and procedures required by N.J.A.C. 8:43A-14.2(b).

7. If the facility provides only computerized tomography, magnetic resonance imaging, or radiological services, the part of N.J.A.C. 8:43A-3.1(a) which requires counseling services to be provided directly by the facility or through written agreement shall not apply.

8:43A-25.2 Additional staffing

(a) In addition to providing other staff as required by the rules in this chapter, a facility providing computerized tomography services shall have at least the following staff:

1. One radiologist available during the facility's hours of operation and on the premises whenever a contrast medium is being used;

2. One radiologic technologist on the premises during the facility's hours of operation; and

3. A radiation physicist/health physicist who shall be available for safety evaluations of equipment and of storage and handling practices, and for staff education.

(b) In addition to providing other staff as required by this chapter, a facility providing magnetic resonance imaging services shall have at least the following staff:

1. A medical director available who is a radiologist and whose primary responsibility during the last three years has been in the interpretation of cross-sectional imaging for all body areas. ("Available" means capable of being reached);

2. One radiologist available during the facility's hours of operation and on the premises whenever a contrast medium is being used;

3. One full-time equivalent technician with documented training and experience in MRI service delivery and one other staff member, both of whom shall be on the premises during the facility's hours of operation; and

4. A radiation physicist/health physicist with documented training and experience in MRI techniques who shall be available.

(c) In addition to providing other staff as required by the rules in this chapter, a facility providing radiological services directly in the facility shall have a radiologist available. ("Available" means capable of being reached.) Radiologists shall supervise and interpret all radiologic procedures, unless performed by clinical practitioners in specialty areas who are trained and experienced in these procedures.

8:43A-25.3 Safety

A facility providing magnetic resonance imaging (MRI), computerized tomography, or other diagnostic services shall develop and implement policies and procedures intended to ensure patient safety during use of all diagnostic equipment.

8:43A-25.4 Physical plant; computerized tomography and magnetic resonance imaging services

A new ambulatory care facility which provides computerized tomography or magnetic resonance imaging services shall comply with Chapter 9, Section 9.1, and Chapter 7, Section 7.10 and 7.11, of the Guidelines for Construction and Equipment of Hospitals and Medical Facilities, 1987 edition, as amended, incorporated herein by reference. Existing facilities shall be in compliance with these standards or the corresponding standards in effect at the time of construction, alteration, or approval.

8:43A-25.5 Physical plant; radiological services

(a) If radiological services are provided in a freestanding facility, the suite shall contain the following:

1. A radiographic room(s), which, if computerized tomography or magnetic resonance imaging services are provided, shall have an area of at least 250 square feet;

2. A film processing room;

3. A viewing area;

4. Film storage facilities for active, inactive, and unexposed film;

5. Office space for medical staff and administrative functions;

6. A waiting area for ambulatory patients and patients requiring wheelchairs or stretchers;

7. A dressing area(s) with convenient access to public toilets;

8. A toilet room(s) with handwashing facilities for staff, visitors, and patients;

9. Handwashing facilities, which shall be available to each procedure room;

10. A control desk and reception area;

11. Storage facilities, including at least the following:

i. A room or closet for storage of the clean linen supply; and

ii. A room for storage of soiled linen; and

12. A janitors' closet, which shall contain a floor receptor or service sink and storage for housekeeping supplies and equipment.

SUBCHAPTER 26. DRUG ABUSE TREATMENT SERVICES

8:43A-26.1 Additional requirements and exceptions

(a) An ambulatory care facility which provides drug abuse treatment services shall comply with N.J.A.C. 8:43A-1 through 11 and *[rules in subchapters]* 13 through 19, and this subchapter.

1. An ambulatory care facility which provides only drug abuse treatment services need not comply with N.J.A.C. 8:43A-6.9 and 8.2 for the purpose of licensure.

8:43A-26.2 Smoking in facility

(a) The facility shall become smoke-free within three months of the effective date of this section. "Smoke-free" means a total ban on smoking in the facility by employees and visitors. Prior to the time at which the facility becomes smoke-free, the policy of the facility regarding smoking in the facility shall be in accordance with N.J.S.A. 26:3D-1 et seq.

1. If the facility permits patients to smoke after the facility becomes smoke-free, smoking by patients shall only be permitted in accordance with N.J.S.A. 26:3D-1 et seq. and in a designated area with outside ventilation. The ventilation system shall prevent contaminated air from recirculating through the facility and shall prevent backstreaming of smoke into nonsmoking areas of the facility.

8:43A-26.3 Additional services

A facility providing drug abuse treatment services shall provide, or arrange provision of, educational services, vocational counseling and training, and job placement to patients whose plans of care indicate a need for such services. In the case of patients who require legal services, the facility shall refer the patient to an agency providing legal services.

8:43A-26.4 Nurse staffing

(a) Ambulatory care facilities which provide drug abuse treatment services shall designate in writing a registered professional nurse as the director of nursing services. The director of nursing services, or a registered professional nurse designated in writing to act in the absence of the director of nursing services, shall be on the premises of the facility whenever medications are being administered and at times specified by the facility in the policy and procedure manual.

1. If the policies and procedures of the facility ensure that the conditions below are satisfied, then the facility need not comply with (a) above ***or with N.J.A.C. 8:43A-8.1***:

i. Medications, including methadone, shall not be dispensed or administered in the facility;

ii. For each patient, the drug counselor to whom the patient is assigned shall obtain health-related information from the patient using a protocol or form approved by the medical director and shall record the information in the patient medical record. If the drug counselor determines that there is a need for immediate intervention by a physician or nurse, the counselor shall immediately notify the

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medical director or registered professional nurse or shall immediately provide the patient with an appropriate referral; ***and***

iii. A physician or a registered professional nurse shall review each patient's health-related information within 15 days of the interview of the patient by the drug counselor. The physician or registered professional nurse shall determine the need for direct assessment by a physician or registered professional nurse or for referral to another health care provider. Direct assessment shall be ordered or referral made on the basis of this determination*[;]***.***

*[iv. A registered professional nurse shall be available to the facility at all times during its hours of operation; and

v. The administrator shall ensure that the duties of the director of nursing services, as specified at N.J.A.C. 8:43A-8.3, are performed]*

(b) In facilities providing methadone detoxification or methadone maintenance services, there shall be at least one registered professional nurse present in the facility for 150 or fewer patients and at least one additional licensed nurse present in the facility for each additional 150 or fewer patients, during all hours when medications are administered.

8:43A-26.5 Drug abuse counseling services

(a) If the facility provides drug abuse treatment services, drug abuse counseling services shall be provided directly in the facility to patients.

(b) A facility providing drug abuse treatment services shall, in addition to complying with N.J.A.C. 8:43A-10, comply with the following:

1. Each patient shall be assigned to a drug counselor, with assignment documented in the patient's medical record. A drug counselor's caseload shall not exceed 50 patients;

2. All outpatient methadone detoxification programs shall provide a minimum of one counseling session per week to each patient during the first four months after initiation of treatment and at least one counseling session every two weeks thereafter until discharged;

3. All outpatient methadone maintenance programs shall assign each patient to one of the following stages and provide counseling to the patient in accordance with the following schedule:

i. Stage I. At least one counseling session per week during the first three months of treatment;

ii. Stage II. At least one counseling session every two weeks from the beginning of the fourth month to the end of the ninth month of treatment;

iii. Stage III. At least one counseling session per month from the beginning of the tenth month to the end of the second year of treatment; and

iv. Stage IV. At least one counseling session every three months after completion of two years of treatment;

4. A patient in an outpatient methadone maintenance program who becomes symptomatic of drug or alcohol abuse for the first time after admission shall return to a minimum of one counseling session per week until symptoms cease and shall remain in his or her present stage of treatment;

5. A patient in an outpatient methadone maintenance program who becomes symptomatic of drug or alcohol abuse for a second or subsequent time after admission may be returned to a lower stage of treatment; and

6. Drug abuse counseling services shall include the provision of individual counseling and the availability of group, family, and/or vocational counseling.

(c) If an administrator performs both administrative and other functions, written documentation of the administrator's time spent in each function shall be maintained. The administrator's time spent in administrative functions shall not be included in the computation of staffing levels for nursing or counseling services.

8:43A-26.6 Designation of consultant pharmacist

If a facility providing methadone detoxification or methadone maintenance services does not have an institutional pharmacy, the facility shall designate a consultant pharmacist who shall review all facility policies and procedures concerning the administration, control, and storage of medications at least semiannually. The consultant pharmacist shall not be affiliated with the pharmacy which provides pharmaceutical services for the facility.

8:43A-26.7 Medical records

The complete medical record for patients receiving drug abuse treatment services shall include, but not be limited to, a copy of the Alcohol and Drug Abuse Data System (ADADS) form (See Appendix A) or other management information system form approved by the Division of Alcoholism, Drug Abuse and Addiction Services of the Department, incorporated herein by reference.

8:43A-26.8 Notices

The hours of operation and the business telephone number of the facility shall be posted so as to be visible from the outside of the main entrance of the facility.

8:43A-26.9 Employee health

The Mantoux tuberculin skin test required by N.J.A.C. 8:43A-3.7(d) shall be repeated on an annual basis for all employees.

SUBCHAPTER 27. SATELLITES OF LICENSED AMBULATORY CARE FACILITIES

8:43A-27.1 Additional requirements and exceptions

(a) A satellite of a licensed ambulatory care facility, as defined at N.J.A.C. 8:43A-1.3, shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter. If the satellite also provides surgical or anesthesia services, then the satellite shall also comply with N.J.A.C. 8:43A-12.

1. A satellite of a licensed ambulatory care facility need not comply with N.J.A.C. 8:43A-2.4(c), 5.1, 6.3(b) and 13.1(c) for the purpose of licensure.

2. The requirements at N.J.A.C. 8:43A-3.6(a) and (b) regarding the availability and accessibility of the policy and procedure manual of the facility shall apply only to those policies and procedures which pertain to the services provided at the satellite facility.

3. The reporting of events as required by N.J.A.C. 8:43A-3.8 may be performed by the licensed facility with which the satellite is affiliated.

4. The information which N.J.A.C. 8:43A-3.9(a)1 and 2 require to be available in the facility may be kept at the licensed facility with which the satellite is affiliated rather than at the satellite itself.

5. The infection prevention and control program required by N.J.A.C. 8:43A-14.1 may be developed at the licensed facility with which the satellite is affiliated, but shall also be implemented at the satellite facility.

6. The written plan for a quality assurance program for patient care required by N.J.A.C. 8:43A-18.1(a) may be developed at the licensed facility with which the satellite is affiliated, but shall also be implemented at the satellite facility.

8:43A-27.2 On-site inspection

An on-site inspection of the construction of the physical plant shall be made by representatives of Health Facilities Construction Services to verify that the building has been constructed in accordance with the architectural plans approved by the Department. The Department may choose to accept an equivalent inspection by a local agency in lieu of an inspection by representatives of Health Facilities Construction Services.

8:43A-27.3 Appointment of administrator

The facility shall appoint an administrator of the satellite who shall be accountable to the governing authority. The administrator of the satellite may be the same person as the administrator of the licensed facility with which the satellite is affiliated. The administrator of the satellite, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available in the satellite facility during its hours of operation.

8:43A-27.4 Patient care policies

All patient care policies and procedures which pertain to the services provided at the satellite facility shall be available in the satellite facility.

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8:43A-27.5 Medical records

(a) Original medical records or components of medical records shall remain on the premises of the satellite or the licensed facility with which the satellite is affiliated unless they are under court order or subpoena or removed in order to safeguard the record in the case of a physical plant emergency or natural disaster. Off-site storage of records may be used only *[with the approval of]* ***if*** the Department ***is given prior notice, including the details of the storage arrangement,*** and only if such storage arrangements will ensure retrieval and delivery of the patient's medical record to the facility within one *[hour]* ***business day*** on a seven day per week, 24 hour per day, basis and immediate availability of medical record information through telephone and facsimile communications systems.

(b) The satellite facility shall develop and implement a system for the establishment and maintenance of medical records for patients who come to the satellite facility on an unscheduled basis.

SUBCHAPTER 28. BIRTH CENTERS

8:43A-28.1 Additional requirements

(a) A birth center shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter.

1. A birth center need not comply with N.J.A.C. 8:43A-7.2 through 7.4 and 8.2 and 8.3 for the purpose of licensure.

(b) No hospital, health care facility or other health care provider shall advertise or claim itself to be a "birth center" unless separately licensed as a birth center under this chapter.

8:43A-28.2 Service restrictions

(a) Surgical procedures provided in the birth center shall be limited to those normally performed during and after uncomplicated childbirth, such as episiotomy and repair, and shall not include operative obstetrics or cesarean sections.

(b) Labor shall not be induced, inhibited, stimulated or augmented with pharmacological agents.

(c) General or conduction anesthesia shall not be administered at the birth center.

(d) The birth center is generally exempt from complying with requirements for anesthesia services at N.J.A.C. 8:43A-12. If anesthetic agents are administered for the purpose of creating conscious sedation, the birth center shall comply with the rules at N.J.A.C. 8:43A-12 which pertains to conscious sedation. Minor conduction blocks and local anesthesia may be administered by a certified nurse midwife in accordance with the scope of practice rules of the Board of Medical Examiners at N.J.A.C. *[8:43A]* ***13:35***-2A.4 and those personnel enumerated at N.J.A.C. 8:43A-12.3(k). The birth center shall establish and implement policies and procedures which address the administration of minor conduction blocks and local anesthesia.

(e) All mothers and infants shall be discharged or transferred within 24 hours from the time of the infant's birth. ***If it becomes necessary to retain a mother and/or infant beyond the 24-hour period, the birth center may do so only if it has been documented in the medical record that the mother and infant were expected to be discharged within 24 hours from the time of the infant's birth.***

8:43A-28.3 Structural organization

(a) The birth center shall be a formal member of a Maternal and Child Health Consortium and shall have been designated as a community perinatal center—birthing center by the Department of Health, in accordance with N.J.A.C. 8:33C.

(b) The birth center shall demonstrate a formal agreement with an affiliated community perinatal center, as defined at N.J.A.C. 8:43A-1.3, located within 20 minutes transport time for medical care of a woman or an infant when complications arise during the antepartum, intrapartum, postpartum or newborn period.

8:43A-28.4 Designation of the clinical director

The governing authority shall designate either an obstetrician in accordance with N.J.A.C. 8:43A-1.17 or a certified nurse midwife to serve as clinical director. The clinical director shall designate, in writing, an obstetrician or a certified nurse midwife to act in the absence of the clinical director. The clinical director, or his or her designee, shall be available to the facility at all times.

8:43A-28.5 Clinical director's responsibilities

(a) The clinical director shall be responsible for the direction, provision, and quality of clinical services provided to patients. He or she shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program. All policies and procedures shall be reviewed at least annually;

2. Assisting in developing and maintaining written job descriptions for the clinical staff and assigning duties based upon education, training, competencies and job descriptions;

3. Participating in staff orientation and staff education activities;

4. Approving the contents, locations, and frequency of checking contents, including expiration dates, of emergency kits or carts, equipment, and supplies, and assigning responsibility for these checks;

5. Developing specifications for verbal orders, including who may give verbal orders, who may receive them, and how soon they must be verified or counterisgned in writing; and

6. Establishing a system for completion of entries in the patient medical record.

8:43A-28.6 *[Physical] ***Physician*** consultation

(a) The birth center shall have a formal consultative relationship with an obstetrician. He or she shall be responsible for the quality of medical care provided, shall approve the birth center's admission criteria and all policies, procedures and protocols related to the medical management of care, and shall be available for consultation and referral.

(b) The birth center shall have a formal consultative relationship with an obstetrician for the purpose of clinical emergencies who has obstetrical privileges that include admission and care of maternity patients at the affiliated community perinatal center. The clinical director of the birth center may fulfill N.J.A.C. 8:43A-28.6(a) and (b), if he or she is an obstetrician.

(c) The birth center shall have a written agreement for services of a pediatrician or group of pediatricians with admitting privileges at the affiliated community perinatal center. This agreement shall ensure that a pediatrician is available at all times.

(d) Any certified nurse midwife practicing in the birth center shall have a written agreement with one or more obstetricians as required by the New Jersey State Board of Medical Examiners rules at N.J.A.C. 13:35-2A.3.

8:43A-28.7 Additional policies and procedures

(a) There shall be written policies and procedures for the prenatal, intrapartal and postpartal care of each patient. The policies and procedures shall be reviewed annually and revised as needed.

(b) The discharge protocol shall include assurance that, within 48 hours after discharge, each patient is called by a designated individual to determine the status of the patient and her newborn. A referral to a home health agency shall be made if clinically indicated.

(c) The birth center shall have a written protocol that sets forth the process to be followed in completing and filing all vital records with the local *[register]* ***registrar*** who has jurisdiction over the municipality where the birth center is located.

(d) The birth center shall have a written protocol to be followed in completing and reporting all newborn screening tests to the Department of Health.

8:43A-28.8 Additional patient care services

(a) A certified nurse-midwife and/or physician shall perform an initial physical assessment of the patient and an evaluation of the patient's medical and emotional needs.

(b) A certified nurse-midwife and/or physician shall develop and implement a plan of care, if needed, for each patient with the patient's participation. The plan shall include at least care and

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treatment to be provided for the duration of the pregnancy, including laboratory studies and provision for the patient's health, psychosocial and nutritional needs.

(c) Each patient shall have at least the following prenatal laboratory tests and diagnostic procedures performed:

1. Urinalysis for glucose and protein;
2. Hemoglobin and hematocrit repeated at 28 weeks;
3. Sickle cells preparation (when appropriate);
4. Rh factor and blood typing;
5. Serological test for syphillis at the first prenatal visit, and in the last trimester of pregnancy or at delivery. If the patient is exposed to an infected partner, a serological test for syphilis shall be performed no sooner than three weeks after exposure;
6. Papanicolaou smear at the first prenatal visit if not documented within the previous six months;
7. Tuberculin test with indicated follow-up if in close contact with a diagnosed case of tuberculosis or from a high-incidence area so designated by the Department;
8. Rubella titer. If this is negative, rubella vaccine with appropriate counseling regarding timing of future pregnancies shall be offered to the patient after delivery and prior to discharge from the birth center;
9. One hour glucose tolerance test at 28 weeks gestation, if indicated by risk factors;
10. Maternal serum alpha-fetoprotein testing offered at 15 to 20 weeks; and
11. Hepatitis B virus screen with appropriate follow-up.

(d) Each patient shall be individually counseled about her progress in pregnancy by a certified nurse-midwife, physician, or a registered professional nurse at every visit, and a progress note shall be recorded in the patient's medical record.

(e) Each patient shall be examined at least once a month during the first seven months of gestation. Thereafter, the patient shall be seen every two weeks until 36 weeks and once a week thereafter. The examination shall be performed by either a certified nurse midwife or a physician.

(f) The results of all tests performed during patient examinations shall be documented in the patient's medical record including at a minimum: blood pressure, weight, dipstick urine analysis for glucose and protein, uterine growth, fetal heart rate, abdominal inspection and palpation, any unusual symptoms reported by the patient, and any physical evidence of abnormality. Evaluation of nutritional status and breast and pelvic examinations shall be documented on a regular basis. ***The medical record shall be in conformance with N.J.A.C. 8:33C-4.3.***

8:43A-28.9 Labor and delivery patient services

(a) All deliveries shall be attended by a certified nurse-midwife, an obstetrician or a family practice physician.

(b) There shall be a second staff member present whenever a patient in active labor is in the facility. This individual shall be a registered professional nurse or an additional certified nurse midwife or physician.

(c) There shall be a health professional certified in neonatal resuscitation present for each delivery.

(d) A complete physical examination of the newborn shall be completed within two hours after birth.

8:43A-28.10 Newborn medical records

(a) The newborn's medical record shall be maintained as a separate record and shall include at least:

1. The date and time of birth;
2. The birth weight and length and head circumference;
3. The condition of the newborn at birth, including the one- and five-minute Apgar scores, details of any physical abnormalities, and any pathological states observed and treatment given;
4. A copy of vital records;
5. Documentation of eye prophylaxis, administration of any other medication or treatment and response, administration of Vitamin K, and performance *[in]* ***of*** inborn error and hearing screenings; and
6. A record of follow-up of mother and newborn following discharge from the birth center.

8:43A-28.11 Maternal-fetal transport and neonatal transport

(a) There shall be a formal transfer/transport agreement between the birth center and the affiliated community perinatal center identified at N.J.A.C. 8:43A-28.3(b).

(b) The birth center shall maintain a written compilation of indicators necessitating transfer and written agreement for acceptance of such transfer patients developed by the affiliated community perinatal center and its staff, in collaboration with the birth center and its staff.

(c) The birth center shall develop a system to ensure continuity of care between the birth center and the transfer hospital, including escort of the patient to the admitting facility by a clinical staff member of the birth center.

8:43A-28.12 Supplies and equipment

(a) The birth center shall be equipped with at least the following:

1. A scrub sink with elbow, wrist, knee, or foot control;
2. Equipment for administering intravenous solutions to adults and newborns;
3. A supply of intravenous solutions including plasma expanders and glucose;
4. Emergency drug supplies;
5. A sphygmomanometer, stethoscope, fetoscope, and thermometer;
6. An infant scale;
7. One sterile pack for use in each birth room with at least one additional pack available. There shall be a written schedule for resterilization;
8. At least one infant warmer. If only one infant warmer is available, it must be transportable into all birth rooms;
9. An infant transport incubator, if not provided by the emergency transport service;
10. Resuscitation equipment for mother and infant;
11. Oxygen with a selection of mask sizes; and
12. Intubation equipment, including laryngoscopes and endotracheal tubes appropriate for adults and newborns.

8:43A-28.13 Additional quality assurance

(a) The quality assurance program shall, in addition to the requirements at N.J.A.C. 8:43A-18, include the following:

1. Review of all transfers of mothers and neonates to hospital care to determine the appropriateness and quality of the transfer; and
2. Review of all problems or complications of pregnancy, labor and postpartum and the appropriateness of the clinical judgement of the practitioner in obtaining consultation and attending to the problem.

SUBCHAPTER 29. EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY SERVICES

8:43A-29.1 Additional requirements

An ambulatory care facility which provides extracorporeal shock wave lithotripsy services shall comply with N.J.A.C. 8:43A-1 through 11 and 13 through 19, and this subchapter. If the facility also provides surgical or anesthesia services, then the facility shall also comply with N.J.A.C. 8:43A-12.

8:43A-29.2 Additional staffing

(a) In addition to providing other staff as required by the rules in this chapter, a facility providing extracorporeal shock wave lithotripsy services shall have at least the following staff:

1. A urologist who shall be able to arrive at the facility within 30 minutes of being called; and
2. An anesthesiologist who shall be able to arrive at the facility within 30 minutes of being called.

(b) Urologists *[and anesthesiologists]* participating in the provision of extracorporeal shock wave lithotripsy services shall be certified by the American Lithotripsy Society (13 Elm Street, Manchester, MA 01944) or the American Urological Association, Inc. (1120 North Charles Street, Baltimore, MD 21201).

8:43A-29.3 Safety

(a) A facility providing extracorporeal shock wave lithotripsy services shall comply with the following:

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1. The policies and procedures of the facility shall identify the staff qualified to participate in the provision of lithotripsy services;

2. Lithotripters shall be inspected at least semiannually by a qualified person. Preventive maintenance shall be documented; and

3. The facility shall develop and implement operational policies addressing at least the following:

i. The maximum number of shocks and/or voltage allowable;

ii. Bilateral treatment;

iii. Females of childbearing age;

iv. Patient weight limitations; and

v. Patients with pacemakers.

8:43A-29.4 Physical plant; extracorporeal shock wave lithotripsy services

(a) The lithotripsy suite of any facility which provides extracorporeal shock wave lithotripsy services shall conform with Chapter 9, Section 9.1B through I, of the Guidelines for Construction and Equipment of Hospital and Medical Facilities (1987 edition, The American Institute of Architects Press) incorporated herein by reference, and shall contain at least the following components:

1. A treatment room, which shall have a minimum of 360 square feet of floor space exclusive of fixed cabinets and built-in shelves. Handwashing facilities shall be located within the treatment room;

2. A cystoscopy room, which shall have a minimum clear area of 250 square feet exclusive of fixed cabinets and built-in shelves. A scrub sink shall be located adjacent to the entrance of the cystoscopy room;

3. Patient holding, induction, and preparation room(s), which shall be equipped with cabinets and handwashing facilities;

4. Patient clothing change areas. The facility shall provide areas in which male and female patients may change from street clothes into appropriate attire and prepare for treatment. These areas shall contain lockers and toilet facilities;

5. A postanesthesia care unit, which shall be designed so as to provide clearance space of at least three feet between patient stretchers and between patient bedsides and adjacent walls. The postanesthesia care unit shall satisfy the requirements of N.J.A.C. 8:43A-12.15 and shall contain at least the following:

i. A nurses station with charting facilities;

ii. A medication distribution station with handwashing facilities;

iii. Toilet facilities; and

iv. A clean holding area or room for the storage of clean and sterile equipment and linens;

6. A reception and information counter and desk;

7. A waiting area with access to a telephone, toilet facilities, and a drinking fountain;

8. A clerical space or room for business transactions and record storage, which shall be separate from public areas for purposes of confidentiality;

9. An enclosed soiled workroom, which shall contain a clinical sink or equivalent flushing-type fixtures, a work counter, and a sink equipped for handwashing;

10. A clean workroom or clean supply room. The clean workroom shall contain a work counter, a sink equipped for handwashing, and space for clean and sterile supplies;

11. A staff lounge and toilet facilities. Separate or combined lounges for male and female staff shall be provided;

12. A clinical report preparation area, which may be accessible from the lounge area;

13. An equipment storage room; and

14. A janitors' closet, which shall contain a floor receptor or service sink and storage for housekeeping supplies and equipment.

(b) New facilities shall comply with (a) above and with subsequent amendments and supplements to the 1987 edition of the standards referenced therein, which are incorporated herein by reference.

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APPENDIX A

ADA-6
Jan. 91

New Jersey State Department of Health

DRUG AND ALCOHOL ADMISSION RECORD

H-4152

Name of Client (First, Middle Initial, Last)	Social Security Number	Telephone Number
	— —	( )

Street Address	City	State	Zip Code

1. Provider Number	2. Case # (1st 3rd 1st 3rd)	3. Sex (M/F)	4. Birthdate (mmddyy)	5. In-House Case No. (optional)	6. Admission Date (mmddyy)

IMPORTANT: After completion of above, separate the Admission Record (Parts 1 and 2) from the Discharge Record (Parts 3 and 4).
USE BALL POINT PEN ONLY. All * fields require coded responses; see codes on the reverse side.

7. Client Type*	8. Treatment Setting at Intake*	9. Is use of methadone planned as part of treatment?	10. Resid. Code (Co. Municip.)	11. Post Office Zip Code
		1 [ ] Yes 2 [ ] No		

12. Living Arrangements (Check ALL that apply)

A [ ] Alone
B [ ] With Children
C [ ] With Sibling(s)
D [ ] With Parent(s)
E [ ] With Spouse
F [ ] Living as Married
G [ ] With Foster Parent(s)
H [ ] With Other Relative(s)
I [ ] With Friend(s)
J [ ] In Group Quarters
K [ ] Homeless

13. Legal Status (Check ALL that apply)

A [ ] No Legal Problem
B [ ] Case Pending (Criminal)
C [ ] Probation
D [ ] Parole
E [ ] DWI License Suspension
F [ ] Jail/Prison Inmate
G [ ] DYFS/Family Court Case
H [ ] Other-Specify _____

14. Household Income Per Year (Enter: 000 if None; 999 if unknown)	15. Household Size (No. of Persons)	16. Race*	17. Indicate Hispanic Origin* (5 if not applicable)
$ ___,000			

18. Marital Status*	19. Highest School Grade Completed	20. Is Client a Full-Time Student?	21. Employment Status*	22. Referral Source*
		1 [ ] Yes 2 [ ] No		

23. Number of Past Drug/Alcohol Treatment Episodes: ___ (Enter: 00 if None; 99 if unknown)

24. Self-Help Groups Ever Participated In (Check ALL That Apply)

A [ ] None
B [ ] Narcotics Anonymous
C [ ] Alcoholics Anonymous
D [ ] Other
Specify: _____

25. Health Coverage*

A ___
B ___

26. Reimbursement Source*

A ___
B ___

[Agencies receiving public funds should note instructions]

27. Check all drugs USED within the past 6 months

___ A. Alcohol
___ B. Heroin
___ C. Non-Prescription Methadone
___ D. Other Opiates or Synthetics
___ E. Cocaine/Crack
___ F. Marijuana/Hashish
___ G. Methamphetamine
___ H. Other Amphetamines
___ I. Other Stimulants
___ J. Benzodiazepines
___ K. Other Tranquilizers
___ L. Barbiturates
___ M. Other Sedatives or Hypnotics
___ N. PCP
___ O. Other Hallucinogens
___ P. Inhalants
___ Q. Over-the-Counter
___ R. Other

27a. Drugs ABUSED	Primary	Secondary	Tertiary
Drug* (Use code letters at left)			
Route of Administration* (see codes below)			
Frequency* (see codes below)			
Age at First Use (99 if unknown)			

ROUTE CODES:	FREQUENCY CODES:
1 - Oral	1 - Not Used in Past Month
2 - Smoking	2 - Less Than Weekly
3 - Inhalation	3 - 1-2 Times Per Week
4 - Intramuscular/ Sub-Cutaneous	4 - 3 to 6 Times Per Week
5 - Intravenous	5 - Daily
	6 - 2 or More Times Per Day

28. Does Client Smoke Tobacco? 1 [ ] Yes 2 [ ] No

If yes, How many cigarettes per day? ___ No. = (Packs X 20) Pipe = PP Cigar = CC

29. SPECIAL USE 5 10 15 20 25 30 35

Name of Agency	Name of Worker

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APPENDIX A

ADA-6
Jan. 91

New Jersey State Department of Health

DRUG AND ALCOHOL DISCHARGE RECORD

Name of Client (First, Middle Initial, Last) | Social Security Number — — | Telephone Number ( )

Street Address | City | State | Zip Code

1. Provider Number | 2. Case # (1st 3rd 1st 3rd) | 3. Sex (M/F) | 4. Birthdate (mmddyy) | 5. In-House Case No. (optional) | 6. Admission Date (mmddyy)

STOP! - Before continuing, remove tissue carbon which extends at bottom. Use Ball Point Pen ONLY.
Press firmly. All * fields require coded responses; see code list on the reverse side.

7. Treatment Setting at Discharge* | 8. Date of Admission to Discharge Setting (mmddyy) | 9. Date of Discharge (mmddyy)

10. Units of Service (non-residential)

(Days/Sessions)

11. Units of Service for Codependents Not Reported Separately (0 if None)

(Sessions)

12. Reason for Termination (Check One)

1 [ ] Treatment Plan Completed
2 [ ] Client Dropped Out
3 [ ] Administrative/Therapeutic Discharge
4 [ ] Deceased
5 [ ] Hospitalized (Medical)
6 [ ] Hospitalized (Psychiatric)
7 [ ] Incarcerated
8 [ ] Other (Specify): _____

13. Significant Problems and Conditions Present at Admission or Identified During Treatment (Check ALL that apply)

[ ] Not Applicable
A [ ] Mental Health Problem
B [ ] Compulsive Gambling
C [ ] Physical Disability/Handicap
D [ ] Victim of Physical Abuse/Neglect
E [ ] Victim of Sexual Abuse
F [ ] Pregnancy
G [ ] Suicide Attempt
H [ ] Runaway Behavior
I [ ] Neglect/Abuse of Clients' Children
J [ ] Child of Substance Abuser
K [ ] Batterer
L [ ] Criminal Activity
M [ ] Other: _____

14. Referrals for Alcohol/Drug Treatment at Discharge* (99 if None)

Setting Code

Non-Agency Referrals (Check ALL that apply)

1 [ ] Employee/Student Assistance Program
2 [ ] Alcoholics Anonymous
3 [ ] Narcotics Anonymous
4 [ ] Family-Oriented Self Help Program
5 [ ] Other Self-Help Program, Specify: _____

15. Psychiatric Diagnoses (Excluding Drug and Alcohol)
[Required for Mental Health Agencies Optional for Others.]

A ____ . ____

B ____ . ____

16. Referrals for Supportive Services (Check ALL that apply)

A [ ] None
B [ ] Clergy
C [ ] Educational
D [ ] Legal
E [ ] Medical
F [ ] Mental Health
G [ ] Public Welfare
H [ ] Pre-Natal
I [ ] Family Services
J [ ] Vocational Rehab.
K [ ] Housing
L [ ] Social Services
M [ ] Employment
N [ ] Food Stamps/Food
O [ ] Women's Center
P [ ] Other _____

17. Evaluation of Client Goal Achievement* (Each item must be answered)
(Enter Code : A-Achieved, B-Partially Achieved, C- Not Achieved, D-Not Applicable)

1 ___ Alcohol/Drug Problem
2 ___ Educational
3 ___ Psycho/Social
4 ___ Employment/Vocational
5 ___ Family Situation
6 ___ Health
7 ___ Legal

18. Is Client Using at Discharge:

A [ ] No B [ ] Alcohol? C [ ] Other Drugs?

19. Employment Status*

20. SPECIAL USE 5 10 15 20 25 30 35

Name of Agency | Name of Worker

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APPENDIX A

CODE LIST FOR ADMISSION AND DISCHARGE FORMS

7. TYPE OF CLIENT *(ADMISSION FORM)*

1 Alcohol/Drug Abuser
2 Parent
3 Spouse
4 Child
5 Other Relative
6 Non-Family

8. TREATMENT SETTING AT INTAKE *(ADMISSION FORM)*
7. TREATMENT SETTING AT DISCHARGE *(DISCHARGE FORM)*
14. REFERRALS FOR ALCOHOL/DRUG TREATMENT *(DISCHARGE FORM)*

01 Counselor/Coordinator
10 Hospital Detox/IMU
15 Residential Detox
20 Short-Term Residential
25 Therapeutic Community/ Long-Term Residential
30 Extended Care
40 Outpatient Care
49 Outpatient Methadone Maintenance
50 Intensive Outpatient
59 Outpatient Detox
60 Halfway House
70 Intervention/Referral

16. RACE *(ADMISSION FORM)*

1 Alaskan Native
2 American Indian
3 Asian/Pacific Islander
4 Black
5 White
6 Other

17. HISPANIC ORIGIN *(ADMISSION FORM)*

1 Puerto Rican
2 Mexican
3 Cuban
4 Other Hispanic
5 Not of Hispanic Origin

18. MARITAL STATUS *(ADMISSION FORM)*

1 Never Married
2 Married
3 Widowed
4 Separated
5 Divorced/Annulled
9 Not Assessed

21. EMPLOYMENT STATUS *(ADMISSION FORM)*
19. EMPLOYMENT STATUS *(DISCHARGE FORM)*

1 Employed Full-Time
2 Employed Part-Time
3 Unemployed-Seeking Work
4 Not in Labor Force
9 Not Assessed

22. REFERRAL SOURCE *(ADMISSION FORM)*

01 Self
02 Family/Friend
03 Alcohol/Drug Treatment Agency/Practitioner
04 Criminal Justice System/Police
05 IDRC/IDP
06 Hospital/Other Health Care Facility
07 Comm. Mental Health/Counseling Service
08 Physician/Psychiatrist
09 Employer/EAP
10 School
11 DYFS
12 Other Social Service Agency
13 Self-Help Group
14 Service Force
15 Other

25. HEALTH COVERAGE *(ADMISSION FORM)*

00 None
01 Medicare
02 Medicaid
03 Blue Cross/Blue Shield
04 Commercial Insurance
05 HMO
98 Other
99 Unknown

26. REIMBURSEMENT SOURCE *(ADMISSION FORM)*

00 None
01 Medicare
02 Medicaid
03 Blue Cross/Blue Shield
04 Commercial Insurance
05 HMO
06 DYFS
07 Div. of Vocational Rehabilitation
08 Municipal Welfare
09 County/State Contract
10 Self Pay
98 Other

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INSURANCE

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Notice of Administrative Correction
Workers' Compensation Self-Insurance
N.J.A.C. 11:2-33.4

Take notice that the Department of Insurance has discovered that the addition of new subsections and paragraphs upon the adoption to adopted new rules N.J.A.C. 11:2-33 (see 25 N.J.R. 1526(a) and 25 N.J.R. 1877(a)) necessitates an additional revision of cross-references at N.J.A.C. 11:2-33.4(b)2. The reference therein to N.J.A.C. 11:2-33.3(e) requires revision to reference N.J.A.C. 11:2-33.3(f). Pursuant to N.J.A.C. 1:30-2.7, this correction is made through this notice.

Full text of the corrected rule is as follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

11:2-33.4 Renewals

(a) (No change.)

(b) In addition to the renewal fee set forth in (a)6 above, upon initial renewal of its certificate the certificate holder shall be assessed and shall pay upon demand the amount necessary to reimburse the Department for expenses incurred in obtaining a risk assessment report on the certificate holder from a rating agency as determined by the Commissioner.

1. (No change.)

2. After the initial submission of the risk assessment report pursuant to N.J.A.C. 11:2-33.3[(e)]**(f)** or 33.4(b), the Department may obtain a risk assessment report on the certificate holder and assess the certificate holder the costs of obtaining such report as set forth herein if the Commissioner determines that the certificate holder's financial condition may have deteriorated, or an event occurs which is reasonably likely to cause the certificate holder's financial condition to deteriorate as provided at (e) below.

(c)-(e) (No change.)

(b)

DIVISION OF ENFORCEMENT AND CONSUMER PROTECTION

Notice of Administrative Correction
Standards of Conduct: Marketing Activities for Which Licensure Not Required
N.J.A.C. 11:17A-1.5

Take notice that the Department of Insurance has discovered an error in the text of N.J.A.C. 11:17A-1.5, as published in the May 17, 1993 update to the New Jersey Administrative Code. In the notice of adoption published at 25 N.J.R. 1878(a), the Department deleted paragraphs (a)1 through 17 and a part of paragraph (a), moving the text as amended (see 25 N.J.R. 446(a)) to a definition of "clerical duties" at N.J.A.C. 11:17A-1.2. However, in the publication of the Code update, the text deleted from N.J.A.C. 11:17A-1.5 upon adoption was not removed from the Code. Such removal is effected by this notice of administrative correction, published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (deletions indicated in brackets [thus]):

11:17A-1.5 Activities for which licensure not required

[(a)] Office employees who perform strictly clerical duties under the supervision and control of an insurer or licensed producer shall not be required to be licensed as an insurance producer. [Such duties shall include, but are not limited to, the following activities:

1. Receiving requests for coverage for transmittal to a licensed insurance producer or for processing through an automated system developed and maintained under the supervision of an insurer or licensed insurance producer;

2. Mailing billings;

3. Scheduling appointments with insurance producers;

4. Office filing;

5. Marketing research or prospecting so long as no attempt is made to solicit or to discuss a specific insurance product or to encourage replacement of an existing policy;

6. Receiving and recording information from an applicant or policyholder and preparing for an insurance producer's review and signature all binders, certificates, endorsements, identification cards or policies pursuant to instructions from the insurance producer;

7. Receiving and recording information from an applicant or policyholder and preparing an application for insurance pursuant to instructions from and for the review of an insurance producer;

8. Receiving and recording information from a policyholder or prospective policyholder to give to an insurance producer for his or her response, or transmitting information to a policyholder or prospective policyholder under the supervision of an insurance producer;

9. Receiving and recording an insured's request concerning any additions or deletions to an existing policy and preparing the appropriate endorsements or processing the appropriate changes through an automated system developed and maintained under the supervision of an insurer or licensed insurance producer and notifying the insurance producer of the endorsements or changes;

Example: An unlicensed person may receive and process a request from an insured to delete an automobile on an existing policy and to add a replacement automobile, or may receive and process a request to delete physical damage coverage on a particular automobile, or receive and process a request for similar routine policy changes initiated by an insured. An unlicensed person may not, however, initiate a change by, for example, telephoning a life insurance policyholder and suggesting that the insured increase the face amount of the policy;

10. Opening mail;

11. Receiving premiums at the recorded place of business where the payment is being made on a binder, endorsement or existing policy;

12. Taking factual information relative to a claim;

13. Communicating with the policyholder or prospective policyholder in order to obtain factual information necessary for an insurance producer to complete a review;

Example: An unlicensed person may call an applicant to request the submission of additional documents.

14. Informing the insured as to his or her coverages as indicated in policy records;

15. Communicating with a prospective or existing insured for the purpose of auditing records or providing loss control on underwriting verifications and inspections;

16. Disseminating buyer's guides, applications for coverage, coverage selection forms or other similar forms in response to a request from prospective or current policyholders; and

Example: An unlicensed person may receive a request for an application and respond by mailing or giving an application for insurance and other related literature. The unlicensed person may not, however, initiate the conversation.

17. Disseminating information as to rates secured by reference to a published or printed list or computer data base of standard rates.

Example: An unlicensed person may respond to a specific request for the cost of a specific coverage from a rate manual published in print or in an electronic format. However, an unlicensed person may not provide advice or suggestions concerning the benefits or drawbacks of a particular coverage, deductible, limit, etc., in the course of disseminating this information.]

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INSURANCE

(a)

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Adopted Concurrent New Rules: N.J.A.C. 11:20 and Appendices

Proposed: July 6, 1993 at 25 N.J.R. 2945(a).

Adopted: August 12, 1993 by the Individual Health Coverage Program, Board of Directors, Charles Wowkanech, Chair.

Filed: August 13, 1993, as R.1993 d.439, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17B:27A-2 et seq.

Effective Date: August 13, 1993.

Expiration Date: August 13, 1998.

Written comments on the proposed new rules were received from 61 commenters. Many general questions were received about the New Jersey Individual Health Coverage ("IHC") Program ("the Program") and its enabling statute, N.J.S.A. 17B:27A-2 et seq., P.L. 1992, c.161, as amended ("the Act") rather than specific questions, comments, or suggestions about the proposed new rules and were not responded to here. The Program Board of Directors ("the Board") intends to establish a system for responding promptly to questions and requests for information about the Program. Questions and request submitted to date will be responded to as soon as possible. Many commenters submitted specific questions relating to a person's eligiblity to retain an existing individual health benefits plan, or to obtain a new individual health benefits plan, when that person is eligible to obtain group health insurance from his or her employer. The interpretation of N.J.S.A. 17B:27A-3(c), which governs these questions, will be the subject of a future proposed new rule; therefore, comments addressing these issues should be submitted in response to the future proposal. Similarly, comments were received on the subject of assessments of program members for losses and administrative expenses of the Program. Assessment procedures and formula for calculating assesssments will be the subject of a future proposed new rule; therefore, comments addressing those aspects of assessments should be submitted in response to the future proposal. The following is a list of organizations and individuals which have submitted written comments directly related to the proposed new rules:

1. Nippon Life Insurance Company of America
2. The Blue Ridge Group, Ltd.
3. Time Insurance Company
4. Noble Lowdes
5. North Carolina Mutual Life Insurance Company
6. Providers Fidelity Life Insurance Company
7. General Accident Insurance
8. The American Hardware Insurance Group
9. Nyemaster, Goode, McLaughlin, Voigts, West Hansell & O'Brien
10. The Mutual Group (U.S.) TMG Life
11. The Principal Financial Group, Principal Mutual Life Insurance Company
12. American United Life Insurance Company
13. Primerica Life Insurance
14. Munich American Reinsurance Company
15. LeBoeuf, Lamb, Leiby & MacRae
16. Home Health Services and Staffing Association of New Jersey
17. Cigna
18. First Consulting & Administration, Inc.
19. Memorial Hospital of Burlington County
20. Tillinghast
21. Oxford Health Plans
22. IHC Companies
23. The New Jersey Dietetic Association, Inc.
24. Health Insurance Committee of the Organization of Lesbian and Gay Architects & Designers, OLGAD
25. Rummel Eye Care
26. Family Eyecare Associates
27. National Casualty Company
28. New Jersey Hospital Association
29. Kessler Institute for Rehabilitation, Inc.
30. State Farm Insurance Company
31. New Jersey Optometric Association
32. JFK Johnson Rehabilitation Institute
33. County of Bergen Department of Health Services, Division of Mental Health
34. HIP Rutgers Health Plan
35. State of New Jersey Department of the Public Advocate, Division of Rate Counsel
36. Jersey Shore Medical Center
37. Ramapo Ridge Psychiatric Hospital
38. Eye Doctors
39. Shelli L. Ravine, O.D.
40. Cliffside Park Eye Associates
41. Freed Vision Center
42. Edward S. Campell, O.D.
43. Snyder Eye Group
44. Brooks Eyecare Associates
45. Michael J. Iulianno, O.D.
46. Greenspan Family Eyecare
47. Campus Eye Group
48. Scott A. Krasny, Esq.
49. Omni Eye Services
50. Allied Vision Services, P.A.
51. Stanley L. Ravine, O.D.
52. Keneth Gasworth, O.D.
53. Debbie H. Kim, O.D.
54. Larry Fuerman, O.D.
55. Richard Ellin, O.D.
56. Bankers Life and Casualty Company
57. Russell E. Bent Government Relations
58. Blue Cross and Blue Shield of New Jersey
59. Mutual of Omaha Companies
60. National Casualty Company
61. Children's Specialized Hospital

Summary of Public Comments and Agency Responses:

COMMENT: Several comments were received from carriers which are not currently writing, and do not intend to write, health care benefits plans in New Jersey, some of which have written business in the past and still have inforce policies, requesting clarification of how the Act affects them.

RESPONSE: Carriers that have inforce health benefits plans in New Jersey are members of the Program and thus are subject to the requirements of the Act whether or not they currently are writing new business. However, carriers that do not have any inforce health benefits plans are not subject to the requirements of the Act.

COMMENT: One commenter asked whether companies that are set up as trusts are required to comply with the Act and any rules promulgated thereunder.

RESPONSE: It is somewhat unclear what the commenter means by "companies that are set up as trusts." Carriers authorized to transact the business of health insurance in New Jersey are subject to the Act. To the extent that a carrier issues individual health benefits plans to New Jersey residents through a trust on or after August 1, 1993, the policies must comply with the health benefits plans approved by the IHC Board.

Carriers may elect not to issue individual health benefits plans to New Jersey residents through a trust or otherwise after July 31, 1993. However, inforce policies, contracts, or certificates which meet the definition of health benefits plan in N.J.A.C. 11:20-1.2 will be included in the net earned premium base for purposes of determining marketshares and allocating assessments for both net reimbursable losses and administrative expenses of the Program, regardless of whether the policies, contracts, or certificates are issued through a trust.

COMMENT: One commenter requested clarification on the impact of the Act on reinsurers and whether the exemption filing requirements are applicable to reinsurers.

RESPONSE: Reinsurance is expressly excluded from the definition of health benefits plan in N.J.A.C. 11:20-1.2; therefore, a reinsurer would not be a member of the IHC Program. A reinsurer which does not write or have inforce health benefits plans and which received New Jersey Individual Health Program Board Bulletin 93-01 should have sent a letter to the Interim Administrator certifying its non-member status.

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COMMENT: Several comments were received from carriers requesting clarification of whether having individual coverage issued pursuant to group health policy conversion rights subjects them to the requirements of the Act.

RESPONSE: Conversion plans are included in the definition of health benefits plans because they are policies or certificates covering individuals. Thus, carriers with conversion policies/certificates inforce are members of the Program and thus subject to the requirements of the Act.

COMMENT: Several commenters asked whether dental- and vision-only plans are health benefits plans, and whether premiums for such plans are included in net earned premiums.

RESPONSE: In N.J.A.C. 11:20-1.2, net earned premium is defined to include only the premiums earned in New Jersey on health benefits plans. Health benefits plan, as defined in N.J.A.C. 11:20-1.2, specifically excludes dental plans and vision plans, whether or not written or on a stand alone basis.

COMMENT: One carrier asked whether the 75 percent minimum loss ratio includes the cost of assessments.

RESPONSE: N.J.A.C. 11:20-7.3 provides that it does.

COMMENT: One commenter asked whether an assessment could be imposed on a carrier that kept existing business in New Jersey on a modified community rated basis.

RESPONSE: Any carrier which delivers, or issues for delivery, health benefits plans in New Jersey is liable to pay an assessment. Carriers which offer the five health benefits plans, or, in the case of Federally-qualified HMOs, the HMO plan formulated by the Board, may apply for an exemption from assessments.

COMMENT: One commenter pointed out that, with respect to Exhibit K, Part C, section 3, premium earned is on an accrual basis while claims paid is on a cash basis and was concerned that the use of two accounting methods was inconsistent.

RESPONSE: Premium earned and claims paid are items required by Exhibit K and are to be completed in accordance with N.J.A.C. 11:20-8.5. These items are defined consistently with N.J.S.A. 17B:27A-11a. Although these two items may be calculated on different bases, the calculation for the purposes of the net paid loss report is equitable for all carriers. In addition, the collection of data in this manner is made easier to verify because of other forms required to be filed by carriers with the New Jersey Department of Insurance.

COMMENT: One commenter asked how a carrier could receive health status information when the application form does not include a field to capture this information.

RESPONSE: No individual health underwriting is permitted under the Act. If the health status information is being requested for the purposes of determining whether a condition is a pre-existing condition, a carrier may obtain health information through its own means.

COMMENT: Several commenters asked when the last time is that an individual health plan may be written before the new plans go into effect.

RESPONSE: On or after August 1, 1993 new policies written must comply with the health benefits plans approved by the Board.

COMMENT: Several commenters remarked that, for carriers who have existing blocks of individual health business, the Act appears to require a transition to community ratings yet, the Act provides in section 2(b)(2) that these plans are exempt from any restrictions except for assessments.

RESPONSE: Existing blocks of business are not required to make the transition to community rating, except for policies that were issued on a modified community rated open enrollment basis. Premiums on all existing health benefits plans will be included in the net earned premiums used for establishment of assessments under section 11 of the Act.

COMMENT: One commenter stated that Act provides that carriers can convert individual policyholders to an equivalent plan developed by the Board and asked whether this conversion can be done as each policy renews, or at one time, and whether the 150 percent, 125 percent rating rules must be applied to these converted cases or the community rate in effect at the time the policy renews.

RESPONSE: Block or portfolio conversion is not mandated. The Board has not yet developed portfolio transition rules and procedures. However, all replacement policies must comply with community rated provisions as of the date of issue if on or after August 1, 1993.

COMMENT: Several commenters asked whether new business written during the remainder of this year would be subject to the loss ratio requirements, or starting in 1994, and whether the loss ratio rules apply to existing blocks of individual business.

RESPONSE: The loss ratio requirements apply to all business issued pursuant to the Act, after August 1, 1993. The initial loss ratio experience reports will cover the period August 1, 1993-December 31, 1993. Exisiting business is subject to current regulations.

COMMENT: Several commenters have requested clarification of whether a policyholder moving into New Jersey may retain coverage obtained out-of-state and whether a New Jersey resident who leaves the State must surrender coverage.

RESPONSE: A carrier may issue policies in states in which it is licensed. A carrier which issued a policy out of New Jersey to a non-New Jersey resident may renew such policy after the policyholder becomes a New Jersey resident. However, any carrier which delivers or issues for delivery an individual health benefits plan as defined in N.J.A.C. 11:20-1.2 must comply with the Act. A delivery or issuance for delivery, to a New Jersey resident of a policy which does not comply with the Act shall not be permitted if the issuance or delivery would circumvent the Act or regulations. When a policyholder leaves New Jersey without the intention to remain a resident, the policyholder is no longer eligible to be insured under an individual health benefits plan.

COMMENT: Several commenters asked whether carriers have to offer all premium payment modes.

RESPONSE: Billing cycles listed on the policy forms are options, not mandates, except that a policyholder must be given the option to pay on a monthly basis. The carrier has the option to offer quarterly and semi-annual modes.

COMMENT: One commenter requested clarification of whether the Program applies to credit accident and sickness insurance.

RESPONSE: The Act and rules do not apply to credit accident and sickness insurance. Credit accident and sickness insurance is specifically excluded from the definition of health benefits plan.

COMMENT: One commenter asked whether the Board's approval of the policy forms was required prior to their issuance and how long such approval would take.

RESPONSE: Policy form filings are "file and use," meaning that the policy form may be used once submitted (with certification, if necessary). See N.J.A.C. 11:20-3.2(a), (b)3. This is also true of the application form; see N.J.A.C. 11:20-4(a) and (b). Such filed forms may be used unless and until they are disapproved by the Board.

The Board has not expressly established an approval period time for forms review. Forms submitted to the Interim Administrator will be reviewed by the Policy Forms Subcommittee, a standing committee of the Board which makes an initial review of the forms submitted, and makes a recommendation to the Board. Forms are not disapproved until the IHC Board acts to disapprove them. The process will be completed as expeditiously as possible, but may vary upon the volume of forms received.

COMMENT: Several commenters asked whether carriers could choose not to market one of the individual health benefits plans established by the Board, pay assessments, and still market an individual medical expense policy other than the standard plans.

RESPONSE: Only standard individual health benefits plan may be issued on or after August 1, 1993. Please refer to N.J.A.C. 11:20-1.3(a).

COMMENT: Several commenters asked whether carriers will be subject to assessments if they do not market any medical expense plan in New Jersey, but still have inforce policies.

RESPONSE: A carrier is a member of the Program, liable for assessments, if it has inforce health benefits plans in New Jersey. Please refer to N.J.A.C. 11:20-1.2 for the definition of "member" and "health benefits plan."

COMMENT: One commenter asked whether there, were any exemption criteria related to the size of inforce block or number of sales per year.

RESPONSE: A member seeking an exemption must have filed with the Board on or before August 1, 1993 and no later than May 1 for all subsequent years, a written request for exemption which shall affirmatively state that the member agrees that it will meet its minimum enrollment, as defined by the Board, and it will not seek reimbursement for losses in any calendar year for which an exemption is sought.

COMMENT: Several carriers asked if they were required to use the Prevailing Healthcare Charges System ("PHCS") available through the

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Health Insurance Association of America ("HIAA") for usual and customary charges determinations if they were currently using a different source.

RESPONSE: The Board recognizes that certain carriers maintain or have access to fee profile databases which may provide equal relevance to New Jersey experience as that of the PHCS. The Board also recognizes that access to the PHCS is subject to restrictions of the HIAA. Given that, the Board believes it is reasonable to allow carriers the opportunity to utilize alternative fee profile databases, so long as in doing so, the intent of the Board to introduce as much standardization and rationalization to the individual health insurance marketplace in New Jersey is preserved. Accordingly, carriers may use alternative fee profiles with a demonstration to the Board of actuarial equivalency between the proposed alternative fee profile and the 80th percentile of the PHCS profile for New Jersey. The Board may disapprove the alternative fee profile if the Board determines that it is not actuarially equivalent to HIAA. A new subsection (e) will be added to N.J.A.C. 11:20-3.1 to reflect this change permitting limited deviation from the reasonable and customary standard proposed by the Board.

COMMENT: One commenter asked whether the coinsurance for mental illness and substance abuse applies to the coinsurance maximum.

RESPONSE: The coinsurance for mental illness and substance abuse applies toward the coinsurance maximum.

COMMENT: Several commenters have requested clarification of the operation of the primary residence requirement.

RESPONSE: An individual who resides for a majority of the calendar year in New Jersey with the intention of making New Jersey his or her home and not for a temporary purpose is a primary resident for the purpose of the eligibility requirements. A temporary absence, with the intention to return to New Jersey, does not interrupt primary residence in New Jersey.

COMMENT: Several commenters asked whether the definition of "therapy services" covers rehab care too.

RESPONSE: "Therapy services," as defined in the standard policy forms, is very specific as to what is and is not included. Certain types of rehabilitative care are covered, others are not as stated in the "Covered Charges and Exclusions" sections.

COMMENT: One commenter asked whether the 30 visit therapy maximum under plans B, C, D, and E covers inpatient and outpatient visits, and remarked that the visit limit is inadequate.

RESPONSE: The 30 visit therapy maximum under plans B, C, D, and E includes all visits, whether inpatient or outpatient.

The Board designed the standard health benefits plans. In establishing the benefit design, the Board was mindful of balancing divergent interests and examined plan designs prevalent in the marketplace before formulating the standard health benefits plans. The adequacy of the standard plans will continue to be evaluated over time.

COMMENT: One commenter pointed out that the Act states that coinsurance and deductibles would not apply to maternity benefits but the policy forms seem to indicate that maternity would be covered at the coinsurance level after a deductible and asked if coinsurance and deductibles apply to maternity.

RESPONSE: Coinsurance and deductibles do apply to maternity benefits. The technical amendments to the Act, P.L.1993, c.164, deleted the language "and neither coinsurance nor deductibles shall apply to maternity benefits or preventative care examinations."

COMMENT: Several commenters asked whether existing policy forms could be used until new policy forms are filed and to what extent an acceptable alternative form may deviate from the standard forms.

RESPONSE: Existing policy forms may be used for policies with effective dates through July 31, 1993. Any policy forms used for policies with effective dates of August 1, 1993 and after must be the standard plans as set forth in rules. In the alternative, a carrier may use forms, in 1993 only, which are in substantial compliance with the standard plans in which case the carrier must submit the forms along with a certification of substantial compliance to the Board prior to marketing the forms. The term "substantial compliance" was intended to indicate that alternative forms should closely adhere to the standard forms in substance and format. Consumers (and the Board) should be able to easily compare the policies of different carriers. The Board may reject alternative forms which change the meaning or effect of material aspects of the standard definitions, exclusions, benefits, or limitations or which impede consumer comparison or Board review. N.J.A.C. 11:20-3.2(b) has been amended to provide clarification.

COMMENT: One commenter asked whether a person previously covered under a group plan that had a 12 month pre-existing condition limitation and had only satisfied six months, would have the six months credited toward the 12 month limitation under an individual plan.

RESPONSE: In accordance with N.J.S.A. 27B:27A-7, a carrier may impose a limitation of no more than 12 months on coverage for pre-existing conditions, except that the pre-existing condition limitation shall not apply to an individual who has, under a prior group or individual health benefits plan, with no intervening lapse in coverage, been treated or diagnosed by a doctor for a condition under that plan or satisfied a 12 month pre-existing condition limitation. A gap in coverage has been defined as no more than 30 days before coverage. In addition, to the extent any individual satisfies a portion of pre-existing condition waiting period under a prior group or individual health benefits plan and is subsequently covered under a new or different individual health benefits plan with no intervening gap in coverage, the portion of the period the individual satisfied will be credited by the new carrier to any period otherwise required. The application will be corrected to conform to the statutory language.

COMMENT: One commenter asked whether an employee who was required to pay the total premiums under a group plan could choose to purchase the individual policy instead.

RESPONSE: Eligibility to purchase an individual health benefits plan is not contingent upon the amount of premium a person may be required to pay under a group health benefits plan. Rather, eligibility is based upon a person's not being eligible for coverage under Medicare, Medicaid or a group health benefits plan providing the same or similar coverage as the individual health benefits plan he or she may wish to purchase. The question of what constitutes same or similar coverage, as stated at the outset, remains to be answered in future rules. Thus, the requirement that an employee pay the total premiums under a group plan does not, in and of itself, make the employee eligible for an individual health benefits plan.

COMMENT: One commenter asked whether an out-of-State parent could obtain an individual policy for chidlren who live in New Jersey, pursuant to a support order.

RESPONSE: There is no approved "child only" rating tier. However, an eligible person can be an adult or child. Although, in this instance, the parent would not be eligible for individual coverage, the child would be. Consequently, the child can be the insured, provided the child meets the eligibility requirements.

COMMENT: The commenter asked for clarification of the effect of applying for an exemption on a carrier's ability to recover subsequent losses because the Act suggests that losses will be reimbursable. The commenter noted that N.J.A.C. 11:20-9.2(b)3 requires a carrier filing for an exemption to agree "not to seek reimbursements for losses the member may incur under the standard health benefits plans in that calendar year for which an exemption is sought by the member."

RESPONSE: Carriers which apply for an exemption in any given calendar year may not seek reimbursement for losses in that year. However, to the extent the carrier fails to meet its minimum number of non-group persons, as determined by the Board, it would be liable for pro-rata share assessments.

COMMENT: One commenter objected that the definition of home health agency contained in the policy forms describes a "Provider which mainly provides skilled nursing care" and asked that the definition be reworded to "a home health care service which provides skilled nursing in a hospital private duty setting, as well as home care."

RESPONSE: The Board agrees that the word "mainly" is unnecessary to ensure that a provider is qualified to provide skilled nursing care. The world "mainly" will be deleted from the definition of home health agency which appears in health benefits plans A through F, Exhibits A through F of N.J.A.C. 11:20.

COMMENT: One commenter asked whether a carrier which offers a group conversion policy as its only individual product in New Jersey is required to stop offering the coverage under their current policy as of August 1, 1993.

RESPONSE: N.J.S.A. 17B:27A-4d requires group conversion contracts to be in compliance with the standard individual health benefits plans, unless there is a direct charge to the group policy from which the conversion is made. This is true regardless of whether the group conversion policy is the only individual product the carrier provides in New Jersey. Hence, if the group conversion policy is not in compliance with the requirements for individual standard health benefits plans, and there

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is no direct charge to the group from which the conversion is made, then the group conversion contract cannot be offered as of August 1, 1993.

The question of what constitutes a direct charge remains to be answered by the Board in future rules. Until then, carriers may assume that the group's subsidization of the group conversion contract is sufficient to exempt its compliance with N.J.S.A. 17B:27A-4d.

COMMENT: Several commenters asked whether Excess Risk (stop loss) insurance, which issues benefits to Employers for employees covered under a self-funded employee health plan, is considered a health benefits plan under the Act.

RESPONSE: Excess Risk (stop loss) insurance is a health benefits plan, for assessment purposes. As long as Excess Risk (stop loss) insurance (1) is issued to self-funded arrangements to reimburse only the self-funded arrangements for expenses exceeding per person or aggregate limits and for which employees or other individuals are not third-party beneficiaries under the policy and (2) the per person limit is no less than $25,000 per year and/or the aggregate limit is no less than 110 percent of expected claims, then any premiums received for such coverage shall not be included in the calculation of a carrier's net earned premium. See N.J.A.C. 11:20-1.2. As long as a carrier has no net earned premium as defined in the rules, the carrier will not be subject to assessments required pursuant to N.J.S.A. 27B:27-11.

COMMENT: One commenter asked whether a carrier which withdraws from the New Jersey market would be liable for assessments.

RESPONSE: A carrier would be liable for an assessment covering any year in which the carrier had net earned premium, as defined in N.J.A.C. 11:20-1.2, in New Jersey.

COMMENT: A commenter asked whether all carriers operating in the New Jersey market during 1992 are liable for the 1992 assessment and whether exemptions are permitted.

RESPONSE: There are no exemptions from assessments for 1992 net paid losses, except for a carrier filing for reimbursement for 1992 losses. The Board recognizes, however, that this is not expressly stated in the Act or rule. Based on a careful evaluation of the Act, the Board has determined that there is no provision in the Act for exemptions from the assessment for 1992 losses. In order to clarify this issue, the Board has included language in N.J.A.C. 11:20-9.2(a) to expressly state that no 1992 exemptions will be granted. This addition to the rule is a clarification of the proposal, not a substantive change in policy and, therefore, no additional notice and comment is necessary.

COMMENT: A commenter questioned whether subsidiaries of a corporation are required to be combined, as affiliated carriers, for assessment purposes, and whether each company must file a separate Exhibit K.

RESPONSE: The definition of carrier at N.J.A.C. 11:20-1.2 treats carriers that are affiliated as one carrier. N.J.A.C. 11:20-8.2(b) requires that affiliated carriers submit a combined Exhibit K report as well as separate reports and, for 1992, allows separate reports in lieu of a combined report.

COMMENT: A commenter requested clarification as to whether the rules require all carriers not actively offering standard plans to be responsible for all expenses of the Program and all losses in excess of 75 percent of premiums incurred by those carriers which do offer standard plans.

RESPONSE: Administrative expenses of the program will be spread over all members of the Program (those that issue or have health benefits plans inforce in New Jersey). All members are responsible for assessments for reimbursing net paid losses, unless the member has received an exemption. Net paid losses equal the excess of paid claims and incurred expenses over earned premium and investment income. Net paid losses are reimbursable for policies which are issued on an open enrolled and either community rated or modified community rated basis (not just the standard plans). In determining a carrier's net paid loss, expenses should equal actual expenses or a maximum of 25 percent of net earned premium, whichever is less.

COMMENT: One commenter asked if, in the event that only a few companies do not offer standard plans, there exists any rule which prevents carriers from being liable for multi-million dollar assessments in years when those companies offering plans qualified for reimbursement for losses exerience very high paid claims.

RESPONSE: The only limitation on assessments is that no carrier would pay more than 35 percent of the total reimbursable losses of the Program.

COMMENT: One commenter asked how expenses of the Program would be assessed if all companies in New Jersey offer standard plans and meet the minimum requirement for number of insureds.

RESPONSE: Administrative expenses will be spread over all members of the Program, regardless of whether the standard plans are offered or exemptions are sought.

COMMENT: One commenter noted, with regard to the definition of health benefits plan and its treatment of hospital confinement indemnity coverage, that proposed N.J.A.C. 11:20-1.2, which excludes only hospital confinement indemnity coverage that provides no more than $250.00 in daily benefits from health benefits plans, appears to conflict with the exemption in the Act for coverages written on a non-expense basis. The commenter suggests that the rules follow the policy of the National Association of Insurance Commissioners regarding limited benefit health coverages, and stated that the purpose of the Act was not to proscribe these coverages when written on a non-expense basis. The commenter suggested that the Board require that an applicant for such coverage certify coverage under a comprehensive health benefits plan and that the hospital confinement indemnity coverage was supplemental only.

RESPONSE: The Board disagrees with the commenter's arguments and suggested changes. While the Act, at N.J.S.A. 17B:27A-2, provides certain exclusions for types of policies which are or may be written on a non-expense incurred basis, it does not expressly exclude coverages because they are written on a non-expense incurred basis. The $250.00 cap placed on hospital confinement indemnity plans which may be excluded from the definition of health benefits plan in the rule is not in conflict with either the Act or N.J.A.C. 11:4-16.6(h). Rather, the $250.00 cap can be read in harmony with the Act and N.J.A.C. 11:4-16.6(h) to clarify what constitutes a hospital confinement indemnity plan. The Board is concerned that hospital confinement indemnity plans with relatively large per diem benefits could be issued to compete with the five health benefits plans and thereby circumvent the intent of the Act, including the minimum loss ratio requirement.

It should be kept in mind that the definition of health benefits plan addresses not only what may and may not be delivered or issued for delivery to individuals in New Jersey on or after August 1, 1993, but also what the premium base will be for purposes of determining marketshare and allocation of assessments for net reimbursable losses and administrative expenses of the Program. For that reason, the commenter's suggestions, including reliance upon the Legislative history of the NAIC's "Small Employer Health Insurance Availability Model Act (Allocation With or Without an Opt-Out)" are not appropriate.

The commenter's suggestion that carriers writing hospital confinement indemnity coverage with a per diem benefit in excess of $250.00 refuse to issue coverage unless the policy is being used to supplement a comprehensive medical and hospital health benefits plan, while attractive, does not address the Board's concern that carriers, individuals (and groups) be prevented, to the greatest extent possible, from creating loopholes in the system established by the Act. There is no way to monitor the accuracy of the application statement subsequent to the date of application (unless the commenter agrees that the hospital confinement indemnity coverage will terminate commensurate with the underlying comprehensive health benefits plan—the public policy consequences of which has not been fully considered). Further, even if monitoring were not a problem, there would still be a question as to the basis for excluding premium for such coverage from the marketshare and assessment allocation base.

COMMENT: Two commenters objected to the definition of "family unit" discriminates against gay couples, lesbian couples, in violation of New Jersey law, and other non-married couples, as well as their children living with them.

RESPONSE: The definition of "family unit" does not violate New Jersey law. Non-married couples may obtain separate health benefits plans on an open-enrollment basis. The definition is drawn narrowly to prevent an individual from bringing another individual under his or her family health benefits plan for the purpose of paying the costs of an illness, even where no legally recognized "partner" relationship exists. If the State of New Jersey decides to grant legal recognition to gay and lesbian marriage in the future, the Board will conform its regulations to the law. Further, the definition of family does not discriminate against a child living with a parent because the child may be covered under a parent's policy regardless of the parent's marital status or affectional or sexual orientation.

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COMMENT: One commenter remarked that the definition of "dependent" in N.J.A.C. 11:20-1.2 is too narrow because it excludes a child's newborn dependent.

RESPONSE: The Board has excluded a child's newborn dependent in order to keep down the cost of premiums on family coverage for herself and the child, or, if she is a dependent, for the child. The mother of a newborn child would be required to obtain separate coverage.

COMMENT: One commenter remarked that the definition of "family" discriminates against children living with their grandparents.

RESPONSE: The definition of "family unit" would include children living with their grandparents if the grandparents were legal guardians. The definition of "child" in the health benefits plans policy forms includes "any child over whom you have legal custody or legal guardianship". A child living with his or her grandparents, where no legal guardianship exists, could be covered by a separate individual health benefits plan.

COMMENT: Several commenters remarked that N.J.A.C. 11:20-3.1 departs from the language of the Act in allowing non-Federally qualified HMOs to offer the HMO plan in lieu of the five health benefits plans approved by the Board.

RESPONSE: The Board agrees that there is a discrepancy and has amended the rule to conform with the Act.

COMMENT: One commenter noted that the exclusion of eye examinations in the policy forms was unqualified and would, therefore, not provide benefits for medically necessary eye examinations for a covered illness (that is, glaucoma or diabetes) or a covered injury (that is, superficial foreign body embedded in the eye). The commenter assumed that such a strict exclusion was unintended and recommended that language be added to clarify that eye examinations solely for the purpose of evaluating refractive error would be excluded while medically necessary eye examinations would be covered.

RESPONSE: The Board never intended to exclude coverage for medically necessary eye examinations and agrees with the commenter that the exclusion is written too broadly. Language has been added to the final rule to clarify that eye examinations "to determine the need for (or changes of) eyeglasses or lenses of any type" are excluded. Eye examinations which are essential to any covered service would not be excluded from coverage.

COMMENT: One commenter recommended that optometry be included in the list of Specialist Doctor Benefits in Section V(b) of Covered Services in the HMO plan.

RESPONSE: The list of specialties covered in this provision is not exclusive. To the extent that a referred service could be provided by an Optometrist, within the scope of the Optometrist's license, the service would be covered.

COMMENT: One commenter asked if a carrier could use its own pre-authorization programs.

RESPONSE: A carrier may use its own pre-authorization program if "pre-authorization" is consistent with, and the programs conform to, the Utilization Review provisions contained in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20.

COMMENT: One commenter objected to the confidentiality of documents provision, N.J.A.C. 11:20-7.5, on the grounds that there was no need to keep loss ratio reports confidential, and that the public should be allowed to view this information and monitor carriers' performance and the function of the Program. The commenter suggested that the Board follow the guidelines of the Right-to-Know Act and the common law and balance the public need to know with the need for confidentiality.

RESPONSE: The Board has reexamined the need for confidentiality of loss ratio reports filed by carriers in light of the commenter's observations. The loss ratio reports are essential to determining whether members of the Program are complying with the minimum loss ratio required by the Act. The Board agrees that the information contained in the loss ratio reports should be available for scrutiny, since consumers will be affected directly by the accuracy of the information reported therein. In the event a carrier's loss ratio is less than 75 percent, the Act provides that policyholders are due a refund of the difference between the net earned premium the carrier received and what would have been necessary to achieve the 75 percent loss ratio.

The Board also believes that, regardless of any protection from disclosure under the Right-to-Know Act this provision might have afforded, the loss ratio reports likely would have been subject to disclosure under the common law. In balancing an individual's need for access to the loss ratio reports against the public interest in confidentiality, the Board believes the need for disclsoure is more weighty. Consumers of health insurance should be able to determine whether a carrier is paying out less in benefits than is required by law. The Board does not believe that the information contained in the loss ratio reports is proprietary or that its disclosure would place any member at a competitive disadvantage. Therefore, the Board has deleted the confidentiality provision from the final rule.

COMMENT: One commenter suggested that the Board add a section to the rules for determination of non-member status.

RESPONSE: The rules define which carrier is a member of the Program. The Board agrees, however, that the continual collection procedures for information required to determine non-member status should be the subject of a rule. Since no such rule was proposed, the recommended amendment cannot be included at this time. The Board intends to address this subject in a future proposal and appreciates the commenter's suggestion.

COMMENT: One commenter questioned whether inpatient rehabilitation services are covered under plan A and objected to the proposed 30-day maximum as inadequate.

RESPONSE: If the rehabilitation services are provided as part of an inpatient hospital stay, the limitation is as set forth in the "Facility Benefit section," and the benefit is only 30 days as an inpatient.

COMMENT: A commenter asked for clarification of the benefit level for therapy services under plan A and noted that all other plans limit this benefit to 30 visits.

RESPONSE: Inpatient and outpatient chemotherapy and radiation therapy are covered under plan A. All other therapy services are covered only on an outpatient basis. Dialysis treatment is not covered.

COMMENT: A commenter asked if spinal manipulations are covered under plan A and noted that this benefit does not appear under "Covered Charges," as it does in the other plans, nor does it appear under "Exclusions."

RESPONSE: Spinal manipulations are not covered. Only the specific coverages listed are covered.

COMMENT: A commenter noted that the skilled nursing and hospice care benefit under plan A is two days for every inpatient day replaced and asked if this translated to a maximum to 60 days.

RESPONSE: If one exchanges every inpatient hospital day for skilled nursing or hospice care, the maximum coverage for these services is 60 days.

COMMENT: A commenter requested clarification of the limitation on inpatient hospital coverage under plan A because the schedule of benefits states that facility coinsurance is 100 percent up to the 30 day maximum.

RESPONSE: The Board agrees that the language is confusing. A covered person's coinsurance is 100 percent after 30 days of inpatient care. There is no benefit for inpatient hospitalization after 30 days. The policy forms will be changed to replace "up to" with "after."

COMMENT: A commenter requested clarification of the emergency room benefit under plan A. The commenter asked if the benefit is limited to $50.00 or if a $50.00 co-pay is required and if the co-pay is credited towards inpatient admission as it does in the other plans.

RESPONSE: The carrier only pays up to $50.00 for an emergency. The insured is responsible for all amounts in excess of the $50.00.

COMMENT: A commenter questioned plan A's schedule of benefits for inpatient hospital admissions, which is a separate $1,000 deductible per admission per covered person with a maximum of two inpatient deductibles per covered person. The commenter asked whether coinsurance applied after the $1,000 deductible and whether the insurer pays anything for the third admission.

RESPONSE: For inpatient hospital admissions, coinsurance applies until the insured has paid $5,000 in coinsurance for hospital inpatient services.

COMMENT: A commenter questioned whether plan A covered 30 days of confinement per calendar year for facility benefits.

RESPONSE: Plan A only covers a maximum of 30 days per year of confinement for inpatient hospital care.

COMMENT: A commenter asked whether, under the benefit for intensive room and board in plan A, the full daily charge for ICU is covered or only up to the semi-private room rate.

RESPONSE: Plan A, Section VI, "Covered Charges," provides that "For Special Care Units, we cover charges up to the Hospital's actual daily room and board charge." The definition of "Special Care Units" in Section I of plan A includes intensive care units.

COMMENT: Two commenters questioned the correctness of the statement under the Coordination of Benefits provisions in the standard

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policy forms which states "If you incur covered charges under this policy and these same expenses are covered under other valid coverage, our payment will be reduced so as not to exceed our pro-rata share of the total coverage available. If we reduce our payment on a pro-rata basis, we will also return a pro-rata share of the premium to you." The commenters question whether this is consistent with current practice.

RESPONSE: Some confusion may arise because individual health benefits plans do not coordinate benefits in the traditional sense (except with New Jersey issued automobile insurance personal injury protection). Rather, individual health benefits plans typically either provide services or benefits regardless of whether other coverage is available to the insured, or include a provision similar to the Coordination of Benefits provision contained in the policy forms reducing or eliminating the carrier's liability to provide services or pay benefits when other valid coverage exists.

Unlike group coordination of benefits, where the carrier allows for the coverage to be either primary or secondary depending upon the circumstances, the individual coordination of benefits provision mandates that the carrier's liability to provide services or benefits will be reduced proportionally to the liability established under other available coverage. To the extent that the carrier's liability is necessarily reduced, a commensurate proportional reduction in premiums is appropriate, and consistent with prior practice on non group health benefits plans which include a reduction or elimination of benefits because of other coverage.

COMMENT: Several commenters took issue with the definition of hospice in Exhibits A through F of N.J.A.C. 11:20 and suggested that the definition be changed to reflect the fact that most hospice care is delivered at home rather than in a facility.

RESPONSE: The Board agrees with the comments and the definition of hospice is being changed as follows:

"A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or

(b) accredited for its stated purpose by the Joint Commission."

COMMENT: One commenter recommended revising the definition of "Home Health Agency" to read as follows:

"A Provider licensed by the State of New Jersey to provide skilled nursing and other professional/para-professional services to people in their home. We will recognize agencies licensed for such services by either the New Jersey Department of Health or the New Jersey Department of Law and Public Safety/Division of Consumer Affairs."

RESPONSE: Plans A through E and plan F, in a medical emergency, do not restrict receipt of care to New Jersey, hence the definition of Home Health Agency needs to be broader than the alternative defined above.

The definition of Home Health Agency included in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20, will be retained with the exception of the deletion of the word "mainly."

COMMENT: One commenter raised a question relating to the requirement for advanced approval under the home health care charges. The commenter felt that there could be problems with certain referrals for home care, particularly, those referrals which occur late Friday afternoon from a hospital discharge planner or physician eager to save the cost of unnecessary extra inpatient days via discharge to home care.

RESPONSE: The intent of the pre-approval requirement applicable to home health care is not to encourage people to remain in the hospital when they could otherwise be discharged. Carriers cannot deny home health care charges simply based upon failure to receive pre-approval when receipt of pre-approval is not reasonably possible. Carriers must either make arrangements to pre-approve home health care seven days a week or accept that denial of home health care cannot be made because of lack of prospective pre-approval when not reasonably possible on the part of the covered person.

COMMENT: One commenter recommended, with regard to the exclusion in N.J.A.C. 11:20, Appendix A, for "experimental" patient care, that "experimental" care be separated into two distinct categories: experimental studies that are part and parcel of research and scientific study patient protocols undertaken by national and governmental agencies and those that are not. The commenter noted that oncology patients are treated with National Cancer Institute research protocols free of charge.

RESPONSE: The definition of "experimental or investigational" as offered in the standard policy forms for the standard health benefit plans, Exhibits A through F of N.J.A.C. 11:20, clarifies what care is considered experimental. Also, services which are provided free of charge are not covered under the policies. No change in the definition of experimental or investigational is being made at this time.

COMMENT: Several commenters objected that the health benefits plans do not cover nutritional counseling and related services, which play an important role in the prevention of many diseases and in the management of chronic diseases such as diabetes and cardiovascular disease. The commenters urged the Board to include nutritional counseling and related services in the proposed regulations.

RESPONSE: The Board developed the standard plan designs as reflected in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20. In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. No change in the benefits relating to nutritional counseling and related services is being made at this time. The Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter remarked, with regard to the basic health benefits plan, that the schedule of benefits for this plan provides for "facility coinsurance" and for a "doctors' service coinsurance"; therefore, the benefit rates for "facility" charges and "doctors' services" charges would be 100 percent of the reasonable and customary charges, minus the applicable coinsurance. The commenter asked what the benefit rate is for other charges; for example, birthing center charges, covered blood charges, home health care charges, outpatient hospital services, pre-admission test charges, skilled nursing center, therapy services, and x-rays and laboratory tests.

RESPONSE: Birthing center charges are covered as facility charges. All the other charges listed above are covered while a person is an inpatient or in lieu of a person's inpatient charges. Subject to all other provisions of the plan, these charges are covered subject to the facility coinsurance.

COMMENT: One commenter asked, with regard to the reporting of experience as required under N.J.A.C. 11:20-7.2 and 7.3, whether the aggregate premiums and losses for all plans are to be reported on a single form, rather than reporting separately the premiums and losses for each of the five plans required to be offered by an insurer.

RESPONSE: The Loss Ratio Report Form should be filed on the basis of separate loss ratio experience for each of the standard health benefits plans written by the member. In addition, separate reports should be completed and filed for each affiliate.

COMMENT: One commenter asked, with regard to the treatment of any refund under N.J.A.C. 11:20-7.4, whether the definition of "premium earned" means that premiums received in the year in which a refund is made should be reduced by the amount of a refund even though the refund relates to premiums earned in the preceding year.

RESPONSE: Carriers should follow their statutory reporting guidelines to determine the appropriate year in which to reduce earned premiums by any refunds made.

COMMENT: Numerous commenters remarked, regarding the definitions of "doctor" and "provider," that the definition of "provider" makes reference to "a recognized facility or practitioner of health care," while the definition of "doctor" concerns a licensed medical practitioner who "provides medical services which are within the scope of the doctor's license or certificate and which are covered by this policy." The commenters suggested that these definitions will create confusion as they do not specify which health care providers are recognized providers under these policies and which are not and recommended that the policies be amended to include additional statements specifying the recognized health care providers under the policies.

RESPONSE: The definition of "doctor" and "provider" in Exhibits A through E of N.J.A.C. 11:20 were written broadly so as to include all legally recognized medical practitioners who provide medical services covered by the policies. The Board believes it would be difficult and unnecessary to exhaustively list all providers.

COMMENT: One commenter remarked that the exclusion of vision therapy, a service ordered by a licensed provider to treat or promote recovery from congenital or acquired visual disorders, and which is a basic form of therapy allied with cognitive rehabilitative therapy, occupational therapy, physical and speech therapy, would increase costs because the only other means of treating eye muscle imbalance would be eye muscle surgery. The commenter recommended that vision therapy be included as a covered expense.

RESPONSE: The Board developed the standard plan designs as reflected in the standard policy forms, Exhibits A through F of N.J.A.C.

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11:20. In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. No change in the vision therapy is being made at this time. The Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter asked whether rehabilitative care is covered under Benefit Plans A through E, since licensed providers of inpatient rehabilitation care are not included in the definition of a hospital. The rule defines rehabilitation center as a facility which mainly provides therapeutic and restorative services to ill or accidentally injured people.

RESPONSE: Under the definitions section in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20, rehabilitative care is covered. The standard policy forms will be revised to clarify that rehabilitative care is covered.

COMMENT: One commenter suggested that, rather than limit outpatient therapy services to a maximum of 30 visits per therapy service, it would be more appropriate to address the services covered based upon a certain number of therapy units per week.

RESPONSE: The Board developed the standard plan designs as reflected in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20. In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. No change in therapy benefits is being made at this time. The Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter asked whether doctor charges for nonsurgical care and treatment of an illness or accidental injury would include doctor charges for inpatient comprehensive rehabilitation care and whether physical procedure and rehabilitation (PM&R) physicians would be included under the definition as a primary care physician for the physically disabled.

RESPONSE: Covered rehabilitative and primary care services could be furnished by anyone who met the definition of provider as defined in the standard policy forms subject to the provisions of the specific plan.

COMMENT: One commenter asked how, under the definition of "skilled nursing center," it is determined when skilled nursing care can take the place of inpatient care. The commenter suggested that language be included regarding the transfer of patients from acute general hospitals to comprehensive rehabilitation hospitals based on quality and patient needs and not purely cost.

RESPONSE: All expenses a person may incur and submit for consideration under the standard health benefits plans are subject to a review of medical necessity and appropriateness. The definition of medically necessary and appropriate included in the Definition section of the standard policy forms, Exhibits A through F of N.J.A.C. 11:20, offers details about what this provision means. Medical necessity and appropriateness does not ignore the person's condition. Cost is not the lone factor that determines what is medically necessary and appropriate.

COMMENT: One commenter asked for clarification of covered therapy services under plan A.

RESPONSE: Chemotherapy and radiation therapy are covered on an inpatient and outpatient basis. Other therapy care, as defined in the Definitions section of plan A, Exhibit A of N.J.A.C. 11:20, is only covered on an inpatient basis.

COMMENT: One commenter asked whether the "facility benefit" of 365 days of inpatient hospital care is applicable toward inpatient comprehensive rehabilitation hospital care and suggested that the coverage of rehabilitation care be clarified.

RESPONSE: The policy form will be revised to clarify that the 365 day limit applies to a rehabilitative center.

COMMENT: One commenter asked whether the inpatient cash Deductibles were applicable to inpatient rehabilitation stays and whether a person would be expected to pay when entering the general acute care facility and again when transferred to a rehabilitation facility.

RESPONSE: The rehabilitative benefit section of the standard policy forms, Exhibits A through F of N.J.A.C. 11:20, is being revised to more clearly state that rehabilitative services are covered. Subject to the provisions of the standard health benefits plans, stays in rehabilitation centers would be subject to the inpatient cash deductible applicable to hospital stays only if the stay in a rehabilitative center is not immdiately preceded by a hospital inpatient stay.

COMMENT: One commenter remarked that comprehensive rehabilitation services were excluded from the benefit plans and suggested that comprehensive rehabilitation services be included.

RESPONSE: The standard policy forms are being revised to more clearly state that rehabilitative services are covered.

COMMENT: One commenter suggested that, with regard to hospice care charges, there is an apparent contradiction, in that payment is prohibited for services supplied to family members other than the terminally ill covered person, as is counseling of any type which is for the sole purpose of adjusting to the terminally ill covered person's death, yet these services are routinely included in hospice care programs. The commenter recommended that such counseling be covered.

RESPONSE: The "hospice care charges" section of the policy forms, items (e) and (f), exclude services and counseling for family members who are not covered by the standard health benefits plans. If a family member is covered by the standard plans, benefits would be provided subject to all other terms of the particular plan. No change is being made in the hospice benefit at this time.

COMMENT: One commenter criticized the absence of mental health care or substance abuse coverage in the Plan A as deficient, the coverage for treatment of mental disorders in plans B through E as grossly inadequate, the co-payments on such coverage as unreasonably high, and the lifetime cap on such coverage as highly unrealistic.

RESPONSE: The Board developed the standard plan designs as reflected in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20. In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market and considered the very issues raised by the commenter at that time. No change in mental illness benefits is being made, but the Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter disapproved that a mental health center be accredited by the Joint Commission or approval by Medicare for the following reasons: community mental health centers are regulated under New Jersey law, with review and oversight through the Division of Mental Health and Hospitals (DMHH) and are not required to be certified by the Joint Commission; the DMHH has published regulations which would provide "certification" of these facilities through the DMHH; and certification by the Joint Commission is too restrictive and costly. The commenter strongly urged that the definition be changed to require only State certification.

RESPONSE: Plans A through E and plan F, in a medical emergency, do not restrict the receipt of care to care received in the State of New Jersey. The Joint Commission accreditation is a broad standard which can be used without having to incorporate an accreditation standard of every state into the policy forms. The Joint Commission standard of accreditation for mental health centers will remain in the standard policy forms, Exhibits A through F of N.J.A.C. 11:20.

COMMENT: One commenter asked what the deadline will be for discontinuing sales of certificates issued through out-of-State trusts.

RESPONSE: The deadline for discontinuing sales of non-standard products is July 31, 1993. Subsequent to August 1, 1993, carriers may no longer sell any health benefits plans to individuals which are not the standard plans approved by the Board.

COMMENT: One commenter asked whether the rule governs the "residual reserve" component of the loss ratio calculation in Exhibit J of the emergency rules and whether the choice of the calculation methods is left to the individual carriers.

RESPONSE: The selection of which residual reserve method to use in the loss ratio calculation is determined by the carrier. A carrier may opt for the safe harbor reserve (3.3 percent of claims incurred for the calendar year and paid through 6/30 of the reporting year), or if their particular experience differs significantly from the 3.3 percent, they may calculate their own reserve, subject to an actuarial certification supporting the calculation. No additional standards have been developed for this purpose.

COMMENT: One commenter asked whether carriers may: add maternity riders which contain a waiting period; add dependents (other than newborns) with health underwriting on pre-August 1, 1993-approved plans; and, issue pre-August 1, 1993-approved plans to insured dependents with conversion privileges under the pre-August 1, 1993 policies.

RESPONSE: N.J.A.C. 11:20-1.3 states that plans issued prior to August 1, 1993 remain under the jurisdiction of the Commissioner of Insurance. Questions regarding changes cannot be answered by the Board.

COMMENT: One commenter asked whether a carrier which decided to exit the individual health market in New Jersey, for any number of reasons, could non-renew contracts which had been inforce for at least one year.

RESPONSE: For policies issued prior to the effective date of the Act, carriers should follow the renewability or termination clauses in their

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contracts. Policies issued pursuant to the Act are renewable except for (a) non-payment of premiums, (b) fraud/misrepresentation, (c) termination of eligibility, or (d) as authorized by the Board.

COMMENT: One commenter noted the need for clarification of the rule for carriers that wish to offer the standard health benefits plans through a managed care network where in-network benefits are directed through a primary care physician. Specifically, the commenter asked for clarification of how to reconcile the interface between in- and out-of-network (referred vs. self-referred) as to benefit levels for prescription drugs and substance abuse/mental health, and the deductibles and coinsurance maximums for inpatient hospital services.

RESPONSE: The Board recognizes that the rule does not provide clear guidance with regard to carriers that wish to offer the standard health benefits plans through a managed care network. In order to facilitate expeditious introduction of health benefits plans, the Board will agree to review a carrier's proposal for reconciling its delivery system with the models for which the policy forms were developed. The Board will add the following provisions to N.J.A.C. 11:20-3.1(d): "4. Notwithstanding (d)1, 2 and 3, a carrier may submit to the Board for approval an alternative managed care delivery system which reconciles its delivery system with the standard health benefits plans."

The following change will be made to N.J.A.C. 11:20-3.2(c): "2. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1, or has not received approval from the Board for health benefits plans described in N.J.A.C. 11:20-3.1(d)4."

COMMENT: One commenter requested that additional requirements be imposed upon a carrier intending to use alternative policy and application forms; specifically, that the carrier explain its basis for using an alternative, and identify the specific differences and why the items of difference do not render the forms out of substantial compliance with the standard forms.

RESPONSE: The Board agrees that, of the benefit for the consumer and the Board, alternative policy forms should closely adhere to the standard forms so they can be easily compared. The language of N.J.A.C. 11:20-3.2 will be clarified to give carriers more guidance in this regard and to require that carriers identify in what ways an alternative form differs from the standard.

COMMENT: One commenter suggested that, in identifying claims incurred and losses suffered, carriers should be required to identify any unusual or extraordinary losses to the Board, as part of the certification required for loss ratio and refund reporting at N.J.A.C. 11:20-7.3.

RESPONSE: The Board disagrees with the commenter's suggestion. The commenter provided no reason the information should be provided, and the Board knows no reason why it should solicit this information. The Board will take this comment under advisement.

COMMENT: One commenter requested that, with respect to N.J.A.C. 11:20-8.5(e), the amount of subsidy reported by Blue Cross and Blue Shield of New Jersey should reflect the amount "received" rather than "approved" by the Hospital Rate Setting Commission for 1992.

RESPONSE: The Board agrees, but believes the most accurate term is "receivable," so that funds which are owed but not received will be factored into the calculation of the 1992 subsidy. The rule will be modified.

COMMENT: One commenter objected to the penalties imposed by a carrier for failure by an individual to obtain authorization for certain medical procedures. the same commenter also asked about the procedures, if any, for subscriber complaints with respect to pre-authorization.

RESPONSE: The Board believes that prior authorization requirements contained in the standard policies are designed to monitor and control medical costs. By notifying the carrier prior to obtaining a medical procedure, the carrier is best able to determine the medical necessity and appropriateness of a requested procedure. Without significant penalties, such as denial of coverage, individuals would have little incentive to obtain prior authorization.

In the event an individual objects to a decision of the carrier, such appeals may be brought to a carrier directly, in the case where a carrier has a complaint procedure in place, and/or to the Board, in accordance with the complaint procedure which will be instituted as part of the Plan of Operation.

COMMENT: One commenter has suggested numerous modifications of the HMO standard plan, stating that they better reflect group model HMO practices.

RESPONSE: Subject to the limitations for use of alternative forms, a carrier may make desired changes in an alternative policy form so long as it remains in substantial compliance with the standard forms. Thus, for example, the term "Associated Medical Groups" may be used in an alternative HMO policy form.

However, the commenter also made several suggestions that the Board has decided to implement, including the following:

On the HMO policy form:

1. The term "premium schedule" on the cover page has been changed to "premiums;"
2. The phrase "we will recognize it if" used in the definition section has been deleted to avoid possible confusion to members;
3. The phrase "or Alcoholics" has been added to the definition of "hospital" after "Substance Abusers;"
4. The sentence "Benefits are per Member, and maximums only apply to the specific services provided," has been added after the first sentence in the Schedule of Services;
5. The phrase "as a result of the emergency" has been added after "24 hours" under the Emergency Room benefit;
6. The phrase "you must have a Referral from Your Primary Care Physician" has been deleted;
7. The phrase "eligible for" was replaced with "covered" in the last sentence of Specialist Services;
8. The word "Medical" has been added to the word "Emergency" to correspond with the defined term "Medical Emergency;"
9. In the Exclusions section, the phrase "artificial and surgical drugs and procedures" has been changed to "artificial drugs and surgical procedures;"
10. Under "facility charges," the phrase "that is not an eligible facility" has been changed to "unless You were referred to the Provider by Your Primary Care Physician;"
11. The hearing examination exclusion has been narrowed to exclude only examinations in conjunction with fitting for hearing aids;
12. Under "Services or Supplies," the last item is preceded by the word "for;"
13. Under "General Provisions—Amendments," the word "that" is added between the words "or" and "of" at the end of the first line;
14. Under "Confidentiality," the phrase "or as may otherwise be provided by law" has been added after the word "us;"
15. Under "Referral of Treatment," the phrase "Advance Directive" has been changed to "advance directive or living will;"
16. Under "Reports and Records," the word "physical" has been changed to "medical;" and
17. Under "The role of Your Primary Care Physician," the phrase "provide services" has been changed to "cover services."

Otherwise in the rules:

1. In N.J.A.C. 11:20-9.2(b), the phrase "if offered" is added where appropriate in subparagraphs ii and iii; and
2. In N.J.A.C. 11:20-9.4(b), the phrase "(a)1 and (a)4" shall be changed to "(a)1 through (a)4."

This commenter also made a number of stylistic, non-substantive recommendations which the Board does not wish to implement at this time. However, the standard policy forms are reviewed by the Board on an ongoing basis in accordance with its responsibility under the Act.

COMMENT: One commenter asked for clarification on the proper percentage of coinsurance for mental and nervous conditions, noting that it was listed as two different percentages in the policy form.

RESPONSE: An error was made under the "Covered Charges" section of the policy. The coinsurance for mental and nervous conditions is 30 percent and the correction has been made.

COMMENT: A commenter requested clarification on the deductible credit applicable for any period of confinement preceding a new benefit period.

RESPONSE: Benefit deductibles and coinsurance are not generally eligible for a carryover credit. However, when a separate cash deductible applies, to the extent that the period of confinement occurred during two benefit periods under a single admission, only one deductible is applicable.

COMMENT: One commenter requested clarification on the application of the inpatient deductible and coinsurance in plan B.

RESPONSE: No benefit is available until a deductible has been fully satisfied. Coinsurance applies after a deductible has been fully satisfied. An inpatient under plan B must meet a $1,000 deductible for each admission, up to two admissions benefit year (calendar year), in full, before any benefit is available. This deductible is stated in terms of a

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$200.00/day deductible, up to five days per admission, up to two admissions. However, the inpatient deductible is not fully satisfied if the full $1,000 deductible was not paid within two admissions. If additional admissions occur in the same benefit period when the full $2,000 deductible has not yet been paid by the inpatient, the $200.00/day deductible continues to apply until the full $2,000 deductible has been paid.

COMMENT: A commenter asked whether a rider is required to plan E in order to replace its deductibles and coinsurance with HMO copayments.

RESPONSE: A carrier that wishes to offer an HMO must offer the standard HMO plan. However, a carrier that wants to offer any of the standard health benefits plans through a managed care network may replace the deductibles and coinsurance with standard HMO copayments under N.J.A.C. 11:20-3.1(d) by filing an alternative policy form with the Board, in accordance with N.J.A.C. 11:20-3.2(b).

COMMENT: One commenter stated a belief that the IHC Program Marketshare and Net Paid Loss Report for HMOs should not include premium earned from Medicare and Medicaid contracts. (See N.J.A.C. 11:20-8 and Exhibit K). The commenter indicated that the belief stemmed from an understanding that Medicare and Medicaid contract premiums would not be considered in the Exhibit K reports. With that in mind, the commenter suggested revision to the HMO data reports, specifically, N.J.A.C. 11:20-8.5(b)4, which specifies the data to be used in reporting net paid losses or gains by HMOs for individual health benefits plans issued or renewed pursuant to N.J.S.A. 17B:27A-3(b)(1) or 4.

RESPONSE: Net earned premium for all group and individual health benefits plans as reported in Exhibit K, Carrier Market Share and Net Paid Loss Report, Part C1 includes premiums from contracts covering Medicaid recipients and premiums from Medicare cost and risk contracts. However, in calculating the Net Paid Loss Report for Individual Health Benefits Plans (Part C3 of Exhibit K), premium earned should not include premium from contracts covering Medicaid recipients and Medicare cost and risk contracts. Therefore, the Board agrees that N.J.A.C. 11:20-8.5(b)4 should be amended to remove "plus 4 plus 5."

COMMENT: One commenter suggested, specifically with respect to the HMO plan (Exhibit F), that two additional grounds for termination of a health benefits plan be added as follows: "(f) Abuse of the system, including, but not limited to, theft, damage to our or participating Provider's property, forgery of drug prescriptions, and consistent failure to keep appointments; or, (g) After reasonable efforts, we or participating Providers are unable to establish and maintain a satisfactory relationship with the member or the Member fails to abide by our rules and regulations, or the Member acts in a manner that is verbally or physically abusive."

RESPONSE: The Board agrees in part with the commenter's suggestion, but notes that the suggested language and its effect are of such a substantive nature that the Board cannot make any of the recommended changes upon adoption of the concurrently proposed rule. Rather, the Board will take the commenter's suggested changes under advisement for possible future amendments to the policy forms.

COMMENT: One commenter stated that the Continuation of Coverage provision of the policy form appears unnecessary given that current New Jersey law now requires guaranteed issue of individual health benefits plans.

RESPONSE: While the Board does not disagree with the commenter, the Board notes that the New Jersey statutes requirng continuation of coverage in limited circumstances under both individual and group health benefits plans were not repealed by the Act, as amended. Traditional statutory construction is to read statutes so that they harmonize, rather than conflict, if possible. To the extent that there is no clear conflict between previous New Jersey statutes, and the Act, as amended, failed to repeal or provide specific exceptions to previous New Jersey statutes, the Board has designed the benefit plans and policy forms to be consistent with all applicable New Jersey statutes. Hence, the continuation of coverage provision is being retained.

COMMENT: One commenter suggested that carriers denied a conditional exemption be granted a hearing. (See N.J.A.C. 11:20-9.5.)

RESPONSE: The Board agrees with the commenter's suggestion, except that the Board believes the discussion most properly belongs at N.J.A.C. 11:20-9.2, and has made the change thereupon adoption by adding a new subsection (e).

Summary of Board-Initiated Changes Upon Adoption:

1. In the definition of "eligible person" in N.J.A.C. 11:20-1.2 the phrase "this state" has been replaced with "New Jersey" to conform with other provisions in the rule.

2. The term "premium" in the definition of "expenses" in N.J.A.C. 11:20-1.2 was changed to "net earned premium" to clarify its meaning.

3. In exclusion number 17 under the definition of "health benefits plan" in N.J.A.C. 11:20-1.2, the term "self-insured" was changed to "self-funded" to clarify that "self-insured arrangements" are not insurance. This conforming change is made wherever the term "self-insured" appears in the proposal.

4. In N.J.A.C. 11:20-1.2, the definition of "individual health benefits plan" was changed to conform to the amended definition in P.L. 1993, c.164, sec. 1, passed by the Legislature subsequent to the proposal. The added language is taken directly from the statute; therefore, additional notice and comment is not necessary.

5. The definition of "informational filing" in N.J.A.C. 11:20-1.2 was moved to N.J.A.C. 11:20-6.2 to avoid confusion with other filings.

6. In N.J.A.C. 11:20-1.2, the definition of "member" was clarified by adding the phrase "in New Jersey" after "health benefits plans." This change addresses confusion expressed by carriers that are licensed to issue health insurance in New Jersey, but do no health insurance business in New Jersey, about whether they are "members" of the Program. This change is not substantive because it adopts similar language in the definition of "health benefits plan."

7. In N.J.A.C. 11:20-1.2, the definition of "net earned premium" was modified to conform with the definition in N.J.S.A. 17B:27A-2 by adding the phrase "the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business." The added language is taken directly from the statute; therefore, additional notice and comment is not necessary.

8. In N.J.A.C. 11:20-1.2, the definition of "standard health benefits plan" is changed by adding an "s" to the word "benefits" to conform with the use of the term elsewhere in the rules.

9. In N.J.A.C. 11:20-1.3, the phrase "these rules" in the last sentence has been changed to "this chapter."

10. In N.J.A.C. 11:20-1.5, "carrier" has been changed to "carrier's" because the word should be possessive.

11. In N.J.A.C. 11:20-3.1, the term "HMO members" in the first sentence has been changed to "Members which are Federally-qualified HMOs" to conform the rule with N.J.S.A. 17B:27A-4(b), which only permits Federally-qualified HMOs to offer a basic health benefits plan in conformance with Federal law in lieu of the five health benefits plans formulated by the Board. The word "all" has been added before the term "HMO member" in the remainder of the paragraph to clarify that both Federally-qualified and non-Federally qualified HMOs offering the Board's HMO plan must comply with the provisions of this section. The proposal has created some ambiguity with respect to non-Federally-qualified HMOs which is clarified by this change. Since the new language conforms the rule with the statute, additional notice and comment is not necessary.

12. In N.J.A.C. 11:20-3.2(b)4ii, the term "substantially compliant" was changed to "in substantial compliance."

13. New paragraphs 5 and 6 have been added to N.J.A.C. 11:20-3.2(b) requesting carriers to describe how their alternative policy forms differ from the standard policy forms, and clarifying what the Board will consider with respect to "substantial compliance" by alternative policy forms to specific standard policy forms. Because the additional language clarifies the term "substantial compliance," and what criteria both carriers and the Board will need to consider in determining what is or is not in substantial compliance, the Board does not believe additional notice and comment is required to make this change upon adoption.

14. A new subsection (c) has been added to N.J.A.C. 11:20-4.1 to clarify what the Board and carriers need to consider in determining whether an alternative application form is in substantial compliance with the standard application form. Because the additional language is a clarification, the Board does not believe additional notice and comment is necessary to make this change upon adoption.

15. As stated above, the definition of "informational filing" was relocated to N.J.A.C. 11:20-6, requiring the introduction of a new section to that subchapter "11:20-6.2 Definitions." The remaining sections of N.J.A.C. 11:20-6 have been recodified accordingly, and citations to the various sections of N.J.A.C. 11:20-6 revised to reflect the renumbering of the sections of the subchapter.

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16. In recodified N.J.A.C. 11:20-6.3(a)1, the word "other" was inserted after the word "any" since the specifically enumerated factors are also prohibited by the Act.

17. At N.J.A.C. 11:20-8.5(a), the citation to N.J.S.A. 17B:27A-3b(1) or (4) has been corrected to remove the parentheses around the number 4, since reference is to N.J.S.A. 17B:27A-4, not to 3b(4), a nonexistent cite.

18. In N.J.A.C. 11:20-8.7, "Board" was changed to "Board's."

19. In Exhibits A, B, C, D, E and F, section II, under the title "CHILD DEPENDENT," the phrase "Child becoming" was changed to "Child's becoming" and the phrase "Dependent becoming" was changed to "Dependent's becoming."

20. In Exhibit A, section III, titled "SCHEDULE OF BENEFITS," and subtitled "FACILITY COINSURANCE," the phrase "up to 30 days" was changed to "after 30 days" to clarify that the covered person pays the entire cost of inpatient care after the first 30 days. The change was made to clarify, not alter the benefit, therefore, additional notice and comment is not necessary.

21. In Exhibits A, B, C, D, E, and F, under the section titled "EXCLUSIONS," the exclusion pertaining to "Illness or Accidental Injury," the words "which occurred on the job or" were deleted to clarify that an illness or accidental injury, regardless of where it occurred, is only excluded from coverage if the covered person was covered or could have been covered for benefits under workers' compensation, employer's liability, occupational disease or similar law. The exclusion was not intended to deny coverage for illness or accidental injury which occurred on the job when no other coverage existed or could have been obtained. This change is technical in nature, not substantive.

22. In Exhibit F, Section I, the last sentence in the definition of "PRIMARY RESIDENCE" was deleted to conform with the definition in the other health benefits plans.

23. In Exhibits A, B, C, D, E and F, the section titled "CHARGES COVERED WITH SPECIAL LIMITATIONS," the last sentence of the second paragraph under the title "Pre-Existing Condition Limitations" was changed to conform with amendments to the law required by P.L.1993, c.164, as follows: [w]e waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, you have been treated or diagnosed by a doctor for a condition under that plan or satisfied a 12 month preexisting limitation." Since the change conforms the regulations with the statute, no additional notice and comment is necessary.

24. In Exhibit G, the cover page to the application form, titled "APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES," paragraph numbered "2" was changed to reflect that the law does not require that family members to be covered under the policy must be New Jersey residents. Since the change conforms the regulations with the statute, no additional notice and comment is necessary.

25. In Exhibit G, on the first page of the application form, in the shaded box titled "Eligible Persons to be Enrolled" was changed to reflect that coverage for unmarried dependent children will terminate when they reach age 20 or 23, if full-time students, on their birthdays rather than at the end of the calendar year. The change is not significant in its effect on either dependent children or carriers and does not require additional notice or opportunity to comment. The next sentence was changed to clarify that mentally and physically handicapped children may remain covered, regardless of age, as long as they are unmarried. The change addresses the possibility that language of the proposed rule, "unmarried and mentally and physically handicapped" could have been read disjunctively rather than conjunctively, to mean that unmarried dependents, regardless of age, could remain covered whether or not mentally or physically handicapped. The change is not substantive and does not require additional notice and opportunity for comment.

26. In the cover page of the application form, a disclaimer has been added to reflect that social security numbers will not be collected or used by the Board and is not, therefore, subject to the requirements of the Privacy Act, 5 U.S.C.A. §552a.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 20
INDIVIDUAL HEALTH COVERAGE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 through 16).

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means an insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in New Jersey. Carriers that are affiliated carriers shall be treated as one carrier.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after November 30, 1992 in which no set portion or part of the premium for the contract or policy is charged to, or subsidized by, the group policy from which the conversion is made.

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person who is a resident of *[this State]* ***New Jersey*** who is not eligible to be insured under a group health benefits plan, Medicare or Medicaid.

"Expenses" means a carrier's actual expenses including commissions to licensed insurance producers calculated on an incurred statutory basis and allocated on a consistent basis to individual lines, or a maximum of 25 percent of ***net earned*** premium, whichever amount is less.

"Family unit" means a legally married man and woman and their dependent child(ren) living in the same household or a single person and his or her dependent child(ren) living in the same household.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. §300e et seq.).

"Group health benefits plan" means a health benefits plan for groups of two or more persons.

"Health benefits plan" means a hospital and medical expense insurance policy, including certificates covering individual New

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Jersey residents, a health service corporation subscriber contract or a health maintenance organization enrollment contract delivered or issued for delivery in New Jersey. The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;
2. Closed blocks of business otherwise meeting the definition of health benefits plan;
3. Executive medical plans;
4. Student coverage which provides more than accident-only coverages;
5. All prescription drug plans whether or not written on a stand alone basis;
6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; and
7. All other health policies, plans or contracts not specifically excluded.

The term "health benefits plan" specifically excludes:

1. Accident-only coverage;
2. Credit insurance;
3. Disability insurance;
4. Long-term care coverage;
5. Coverage arising out of a worker's compensation or similar law;
6. Automobile medical payment insurance or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.;
7. Medical coverage provided as part of a liability policy;
8. Medical coverage provided as a rider to a non-medical benefits plan, wherein the medical coverage constitutes less than five percent of the premium for the benefits plan, including riders, and therefore is an incidental part of the benefits plan's coverage;
9. Hospital confinement indemnity coverage so long as the coverage is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than $40.00 but no more than $250.00 in daily benefits;
10. Dental plans, whether or not written on a stand alone basis;
11. Vision care plans, whether or not written on a stand alone basis;
12. Reinsurance;
13. Coverage for Medicaid services provided pursuant to a contract with the State of New Jersey;
14. Medicare risk and cost contracts as defined in this section;
15. Coverage which is specifically advertised, marketed and designed to supplement CHAMPUS;
16. Medicare supplement coverage to the extent that such coverage meets the requirements of N.J.A.C. 11:4-23, Minimum Standards for Medicare Supplement Coverage, and is coverage that is reported on the Medicare Supplement Insurance Experience Exhibit of the NAIC Annual Statement blank for Life and Accident and Health Insurance or Health Maintenance Organizations; and
17. Self *[insured]* ***-funded*** arrangements for which revenue is not included as premium for statutory reporting purposes.

"HealthStart Plus" means the program providing coverage to pregnant women and infants up to one year of age who are in families with incomes between 185 percent and 300 percent of the poverty level, established pursuant to the Health Care Cost Reduction Act, P.L. 1991, c.187, s.25 (N.J.S.A. 26:2H-18.47).

"IHC Program" means the New Jersey Individual Health Coverage Program.

"Individual health benefits plan" means***: (a)*** a health benefits plan for eligible persons and their dependents***; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy of contract pursuant to continuation of benefits provisions applicable under Federal or State law.**

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is established or adopted by two or more employers, by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or organizations.*

["Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.]

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. §1395 et seq.) and amendments thereto.

"Medicare cost and risk contracts" means policies or contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.) and amendments thereto.

"Member" means a carrier that issues or has in force health benefits plans ***in New Jersey***.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but with differentiation by health status.

"NAIC" means the National Association of Insurance Commissioners.

"Net earned premium" means the premiums earned in New Jersey on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. "Net earned premium" shall include ***the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including*** premiums from contracts covering Medicaid and HealthStart Plus recipients and premiums from Medicare cost and risk contracts. "Net earned premium" shall not include premiums from any stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-*[insured]* ***funded*** arrangements to reimburse only the self-*[insured]* ***funded*** arrangement for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and
2. The per person limit is no less than $25,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 110 percent of expected claims.

"Non-group persons" include individually enrolled persons, persons covered by conversion policies issued pursuant to the Act, Medicare cost and risk lives and Medicaid and HealthStart Plus recipients.

"Open enrollment" means the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis.

"Pre-existing condition" means a condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

"Premium earned" means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

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"Program" means the New Jersey Individual Health Coverage Program established pursuant to the Act.

"Public Advocate" means the New Jersey Department of the Public Advocate, Division of Rate Counsel.

"Reasonable and customary" means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey for various medical services and supplies, published and available from the Health Insurance Association of America.

"Reimbursement for losses" means reimbursements distributed through the IHC Program to cover losses, in whole or in part, incurred by members applying for reimbursements with respect to individual standard health benefits plans beginning in calendar year 1993 and thereafter.

"Resident" means a person whose primary residence for the majority of a year is in the State of New Jersey.

"Standard health benefits plan" means a health benefit**s** plan, including riders, if any, adopted by the IHC Program Board.

11:20-1.3 Closing of noncomplying individual health benefits plans

(a) Carriers may begin to market individual standard health benefits plans as defined at N.J.A.C. 11:20-3 on or after July 1, 1993, but not before; those standard health benefits plans shall not have a coverage effective date prior to August 1, 1993. All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with *[these rules]* ***this chapter***.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with N.J.S.A. 17B:26-1 et seq., N.J.S.A. 17:48E-1 et seq., N.J.S.A. 26:2J-1 et seq. and rules promulgated pursuant thereto.

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, including individual standard health benefits plans, shall be subject to the Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by the Act.

11:20-1.5 Penalties

Failure of a carrier to comply with any provision of this chapter may result in the carrier**'s** losing its authority to write health benefits in New Jersey and imposition of any and all penalties and actions available under law.

11:20-1.6 Severability

If any provision of this chapter or the application thereof to any person or circumstance is found to be invalid for any reason, the remainder of the chapter and the application thereof to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 2. (RESERVED)

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 Benefits provided

(a) The standard individual health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, "The Basic Health Benefits Plans," Exhibit A, sections III, V, VI, VII and IX;

2. Plan B, "Individual Health Benefits Plan B," Exhibit B, sections III, V, VI, VII and IX;

3. Plan C, "Individual Health Benefits Plan C," Exhibit C, sections III, V, VI, VII and IX;

4. Plan D, "Individual Health Benefits Plan D," Exhibit D, sections III, V, VI, VII and IX;

5. Plan E, "Individual Health Benefits Plan E," Exhibit E, sections III, V, VI, VII and IX; and

6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F, sections III, V, and VI.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A, B, C, D and E as set forth in Exhibits A through E, respectively, in the Appendix.

1. Members offering Plans B, C, and D shall offer the following annual deductible options to the policyholder for each plan:

i. $250.00 per individual and $500.00 per family unit;

ii. $500.00 per individual and $1,000 per family unit;

iii. $1,000 per individual and $2,000 per family unit.

2. Members offering Plan E shall offer the following annual deductible options to the policyholder for this plan:

i. $150.00 per individual and $300.00 per family unit;

ii. $500.00 per individual and $1,000 per family unit;

iii. $1,000 per individual and $2,000 per family unit.

(c) *[HMO members]* ***Members which are Federally-qualified HMOs*** may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans A through E in (a) above. ***All*** HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient copay, $50.00 separate emergency room copay, $15.00 for all other copays. ***All*** HMO members choosing to offer optional health benefits plans may offer one or both of the following copayment options, provided that all options marketed shall be offered to each applicant:

1. $250.00 hospital inpatient copay, $200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $20.00 for all other copays; and/or

2. $100.00 hospital inpatient copay, $100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $10.00 for all other copays.

(d) Each of the standard health benefits plans may be offered through or in conjunction with a managed care network, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;

2. The coinsurance maximum specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits A through E in the Appendix, shall be the coinsurance maximum for the in-network and out-network benefits combined; and

3. The HMO Plan standard copayment level ($15.00) may be substituted for deductibles applicable to in-network benefits.

4. Notwithstanding (d)1, 2 and 3 above, a carrier may submit to the Board for approval an alternative managed care delivery system which reconciles its delivery system with the standard health benefit plans.

(e) In paying benefits for covered services provided by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges on a reasonable and customary basis as defined by the Board, except that a carrier may pay using an alternative different fee profile from that adopted by the Board.

1. Upon filing with the Interim Administrator, a member may use such alternative fee profile unless and until it has been disapproved in accordance with this subsection. Such alternative fee profile shall be submitted with supporting documentation of actuarial equivalency to the Board's proposed definition of reasonable and customary.

2. After notice and a hearing, conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, the Board shall disapprove any such proposed alternative fee profile that is not actuarially equivalent to the Board's proposed definition of reasonable and customary.*

11:20-3.2 Policy forms

(a) For standard health benefits plans policies effective on or after August 1, 1993, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F, except as provided in (b) below. Before marketing the standard policy forms, a member shall file in triplicate with the Board a certification signed by the Chief Executive Officer of the member that sets forth that the standard policy forms will be used by the member.

(b) As a transitional measure, a member may submit to the Board alternative policy forms for the standard health benefits plans, so long as the alternative policy forms are in substantial compliance

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with the standard policy forms set forth in the Appendix. These alternative policy forms may be used, except as provided in (b)3 and 4 below, until the next anniversary date at which time the member shall issue a standard policy form in accordance with (a) above.

1. The alternative policy form shall be submitted with a certification of the Chief Executive Officer of the member that the policy form submitted for approval is in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20.

2. Alternative individual health benefits plan policy forms shall be submitted in triplicate to the Board at the following address:

Interim Administrator
Individual Health Coverage Program Board
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

3. Upon filing, a member may use an alternative policy form unless and until it has been disapproved in accordance with this rule.

4. After notice and a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, the Board shall disapprove any proposed alternative policy form that:

i. Is not in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-3;

ii. Is not *[substantially compliant]* ***in substantial compliance*** with the corresponding standard policy form set forth in the Appendix to this subchapter; and

iii. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1.

***5. When submitting alternative policy forms, carriers shall submit, along with the certification of substantial compliance, a description of the differences between the alternative policy form(s) and the standard policy form(s) set forth in Exhibits A through F in the Appendix of this chapter, as appropriate.**

6. In determining substantial compliance of the alternative policy form with the specific standard policy form, the carrier shall consider in its certification, and the Board shall consider in its review of the alternative policy form and certification whether:

i. The inclusion of words, terms and descriptions not contained in the standard policy forms changes the meaning or effect of any material aspect of the standard health benefits plans or standard application form;

ii. The alternative policy form contains all provisions required by New Jersey law and the standard policy form which, if not the same as that required by law or in the standard policy form, is at least as favorable to the insured or policyholder;

iii. The alternative policy form contains all coverages, coverage limits, and exclusions set forth in the standard policy form;

iv. There is any deviation from the effective date of coverage, renewal or termination provisions in the standard policy forms; and

v. Easy comparison with the appropriate standard policy form by both the consumer and the Board is impeded.*

(c) Notwithstanding the provisions of (a) and (b) above, a member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20-3.1(d) shall submit alternative policy forms which are consistent with N.J.A.C. 11:20-3.1(d) and the purposes of the Act. Upon filing, a member may use such alternative policy form unless and until it has been disapproved in accordance with this rule. Such forms shall be submitted in accordance with (b)2 above. The alternative policy form shall be submitted with a certification of the Chief Executive Officer of the member that the policy form submitted is in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20. After notice and a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, the Board shall disapprove any such proposed alternative policy form that:

1. Is not in substantial compliance with N.J.S.A. 17B:27A-2 et seq., and this subchapter; or

2. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1***, or has not received approval from the Board for health benefits plans described in N.J.A.C. 11:20-3.1(d)4***.

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20-4.1 Standard application form

(a) All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G of the Appendix to this chapter, except as provided in (b) below.

(b) A member may submit to the Board for approval an alternative application form that differs in format but not in content from the standard form set forth in Exhibit G of the Appendix. The member may use the alternative form when submitted unless and until disapproved by the Board.

1. The alternative application form shall be submitted with a certification by the Chief Executive Officer of the member that the alternative application form requests only the information specified in the form in Exhibit G of the Appendix.

2. Alternative application forms shall be submitted in triplicate to the Board at the following address:

Interim Administrator
Individual Health Coverage Program Board
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

3. The Board shall disapprove any alternative application form that is not consistent with the purpose of this chapter.

4. If any proposed alternative application form is disapproved, it may not be used with a policy form delivered or issued for delivery unless and until such disapproval is withdrawn.

5. Upon request by the member for a hearing, the Board's disapproval of an alternative application form shall be subject to review in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(c) In determining substantial compliance, the Board and carrier shall consider whether the alternative application form includes all information required by the standard application form, even information which applies are required to complete at their option, but no information relevant to underwriting or rating of the individual not otherwise contained in the standard application form.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:20-5.1 Standard Claim Form

Effective August 1, 1993, all members offering health benefits plans or other health insurance policies to individuals shall, to the extent that the member uses claims forms in its transaction of business, require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The standard claim form shall be used for all medical expenses incurrecd for services other than hospital inpatient services. Members shall use form UB-82 set forth as Exhibit I in the Appendix to this chapter for hospital inpatient services.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section 2b(1) and 3 of the Act (N.J.S.A. 17B:-27A-3b(1) and 17B:27A-4).

*11:20-6.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

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"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.*

11:20-*[6.2]***6.3*** Informational filing requirements

(a) All members issuing standard health benefits plans or conversion health benefits plans on a new contract or policy form shall make, prior to issuing any standard health benefits plan or conversion benefits plan, an informational filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any ***other*** factors prohibited by the Act;

2. Premium rates and any factors used in the calculation of the premium rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date, and may be developed on different rate tiers for family units (that is, different community rates for individuals, two-person families and larger families) provided that all proposed rates applicable in this State have been filed with the Board before being used;

3. A detailed actuarial memorandum, which shall include the following:

i. The rates being submitted;

ii. All information used in the development of the rates;

iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and

iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

4. A certification signed by a member of the American Academy of Actuaries, which shall include the following:

i. A statement that the informational filing is complete; and

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent; and

5. Such other information or data as may be required or requested by the Board to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans, conversion health benefits plans, or its community rated and modified community rated health benefits plans issued prior to June 14, 1993 shall, prior to the effective date of the revised rates, submit to the Board an informational filing, which shall include all the supporting data set forth in (a) above.

11:20-*[6.3]***6.4*** Informational filing procedures

(a) The informational filing filed by the member with the Board pursuant to N.J.A.C. 11:20-*[6.2]***6.3***(a) or (b) above shall be filed in triplicate as follows:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, NJ 08830

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20-*[6.2]***6.3***(a) or (b) above is incomplete, the Board shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Upon 15 days of receipt of written notice in (b) above, the member shall provide the Board with the information required to complete the filing.

(d) Upon notice that the filing is incomplete, the member shall not use the filed rates until the Board has determined that the informational filing is complete, and written notice of that fact has been provided to the member.

(e) The Board shall, within 15 days of receipt of a member's informational rate filing and within 15 days of receipt of any material submitted or resubmitted by a member at the request of the Board in accordance with (b) above, submit copies of the filing to the Commissioner and to the Public Advocate as follows:

Commissioner of Insurance
ATTN: IHCP Rate Filings
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625-0325

Division of Rate Counsel
Department of the Public Advocate
Hughes Justice Complex
CN-850
Trenton, NJ 08625

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:20-7.2 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan in force during the preceding calendar year shall file with the Board an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter incorporated herein by reference.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans policy forms written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 for the calendar year immediately preceding.

11:20-7.3 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form shall be completed annually by each member and shall include the following information:

1. The reporting member's name and address;

2. The member's net earned premium for standard health benefits plan during the calendar year immediately preceding;

3. A statement of the member's total losses incurred consisting of:

i. Claims incurred during the calendar year and paid through June 30 of the reporting year; plus

ii. Residual reserve consisting of:

(1) Safeharbor reserve (3.3 percent of (a)3i above); or

(2) Calculated residual reserve (supported by actuarial certification); and

iii. A pro rata share of any assessment paid during the period, determined as the member's total assessment multiplied by the net earned premium for standard health benefits plans divided by the net earned premiums for all of the member's health benefits plans;

4. The member's loss ratio (determined by dividing the total losses incurred by the net earned premium as determined in (a)2 above);

5. Certification by a member of the American Academy of Actuaries that the information provided in the Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with instructions; and

6. Such other information as the Board may request.

11:20-7.4 Refund plan

If the calendar year loss ratio is less than 75 percent, the member shall include with the Report a plan to be approved by the Board for a prompt refund to policy and contract holders of the difference between the amount of net earned premium it received that year on the standard health benefits plans and the amount that would have been necessary to achieve the 75 percent loss ratio.

*[11:20-7.5 Confidentiality of documents

All documents submitted to the Board pursuant to this subchapter are confidential and not public documents as defined in the "Right-to-Know" Law, N.J.S.A. 47:1A-1 et seq.]*

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SUBCHAPTER 8. THE IHC PROGRAM MARKET SHARE AND NET PAID LOSS REPORT

11:20-8.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data and losses to determine the total amount of losses which are reimbursable, and the allocation of assessments for reimbursement of those losses, as well as a basis for determining criteria to be met by carriers requesting exemption from such assessments.

(b) This subchapter shall apply to all carriers that are or become members of the New Jersey Individual Health Coverage Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member at the time that the report is to be filed.

11:20-8.2 Filing of the market share and net paid loss report form

(a) Every member of the IHC Program shall file the report form set forth as Exhibit K in the Appendix to this chapter, on or before June 28, 1993 and annually thereafter no later than March 1. Every member shall complete Parts A, B, C and D of the report form, whether or not the member is seeking reimbursements for losses, or exemptions from assessments for losses.

(b) Affiliated carriers shall submit a combined report using the report form set forth as Exhibit K in the Appendix.

1. The combined report form shall be submitted under the name of one of the affiliated carrier's members, and shall include as attachments the separate reports of each of the members of the affiliated carrier including the separate report of the member submitting the combined report form, all as one package.

2. In lieu of a combined report for the filing due June 28, 1993, members of an affiliated carrier may submit their separate report forms with an attachment listing the other members within the affiliated carrier.

(c) Certified report forms shall be submitted by facsimile to the Interim Administrator at (908) 632-7409, or to:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, NJ 08830

11:20-8.3 Net earned premium

(a) Every member shall set forth its net earned premium for the preceding calendar year ending December 31 in Part C1 of the report.

1. Net earned premium set forth in Part C1 of the report form shall include net earned premium resulting from group health benefits plans and individual health benefits plans issued, continued or renewed during the preceding calendar year, including premiums from conversion health benefits plans.

2. Net earned premium reported in Part C1 of the report form shall be based upon, if not the same as, the data set forth in the member's annual reports, as follows, adjusted to meet the definitions set forth in this subchapter as necessary:

i. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 3 less Column 4, line 23 plus line 23.2 plus line 24.6;

ii. The NAIC Fire and Casualty Blank (Yellow), State page 14 entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, line 13 plus line 15.1 through line 15.6;

iii. The NAIC HMDI Blank (White), page 6, entitled "Underwriting and Investment Exhibit," Part 1, Line 5, Column 9 less (Column 2 minus Column 3), and less reinsurance portions of (Column 5 minus Column 8);

iv. The New Jersey State HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Lines 1 plus 2 plus 4 plus 5; or

v. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Lines 1 plus 2 plus 3 plus 4.

11:20-8.4 Calculation of covered non-group persons

Members shall report in Part C2 of the report form the total number of persons covered under individual community rated health benefits plans, individual modified community rated health benefits plans, conversion health benefits plans, the number of Medicaid recipients covered by the member under a contract with the State of New Jersey, and Medicare lives covered by the member under Medicare cost and risk contracts with the Federal government, and contracts covering actual HealthStart Plus recipients, as of December 31 of the preceding calendar year.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes of completing Part C3 of the report form, members shall provide data for their individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A-3b(1) or *[(]*4*[)]*), for the preceding calendar year ending December 31.

1. All data shall be for direct business only; reinsurance accepted shall not be included, and reinsurance ceded shall not be deducted.

2. The method used by a member to allocate to sublines of the individual line shall be consistent with the method used by a member to allocate to the individual line.

(b) Premium earned shall be adjusted by any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the following bases, as appropriate to the member, adjusted for the individual health benefits plan for which the report is being made, as necessary:

1. The NAIC Life and Health Blank (Blue), State page 19 entitled "Accident and Health Insurance," Column 3 less Column 4, line 23.2 plus 24.6;

2. The NAIC Fire and Casualty Blank (Yellow), State page 14, entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, lines 15.1 through 15.6;

3. The NAIC HMDI Blank (White), Exhibit 5, entitled "Underwriting Gains and (Losses) by Enrollment Classification," Column 3, sections 2 plus 3 less Complementary Medicare and less reinsurance;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 1 plus 2 *[plus 4 plus 5]*; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Lines 1 plus 2 plus 3 plus 4.

(c) In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member, adjusted as necessary for the individual health benefits plans for which the report is being made, with the following serving as the basis:

1. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 5, line 23.2 plus line 24.6;

2. The NAIC Fire and Casualty Blank (Yellow), State page 14, entitled "Exhibit of Premiums and Losses," Column 6, lines 15.1 through 15.6;

3. The NAIC HMDI Blank (White), Underwriting and Investment Exhibit, Part 2, Column 2, less reinsurance, adjusted to Individual, less Complementary Medicare and Group;

4. The New Jersey State HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year (Lines 20 minus 7 minus 3 minus 17) less page 31, Report No. 1, Part B, (Column 3, line 2 through 6 less Column 4, lines 2 through 6); or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, (Lines 16 plus 20) less Report No. 1, Part B, ((Column 3, Lines 2 plus 3) minus (Column 4, Lines 2 plus 3)).

(d) Expenses shall reflect current expense items only and shall exclude prior period adjustments as well as excluding surplus adjustments and Federal and State income taxes. Expenses shall include premium taxes and commissions. Expenses shall be reported consistent with the following bases, as appropriate to the member, adjusted for New Jersey, and adjusted for the individual health benefits plans for which the report is being made, as necessary, but in no instance shall expenses exceed 25 percent of premium earned:

1. The NAIC Life and Health Blank (Blue), page 6, entitled "Analysis of Operations by Lines of Business," Column 11, lines 20, 22, and 23 (less State income taxes);

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2. The NAIC Fire and Casualty Blank (Yellow), Insurance Expenses Exhibit, Part III, Columns 5, 6, 12, 13, 14, 15, line 15;

3. The NAIC HMDI Blank (White), Exhibit 5, entitled "Underwriting Gains and (Losses) by Enrollment Classification," Column 5, sections 2 plus 3 less Complementary Medicare and less reinsurance;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 26; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Line 27.

(e) Blue Cross and Blue Shield of New Jersey, Inc. shall report the amount of subsidy ***receivable based upon discount factors*** approved by the Hospital Rate Setting Commission for its individual line of business in 1992, not including the "fast payor" discount factor included in the 1992 hospital payor differential.

(f) Net investment income shall be calculated in accordance with statutory reporting requirements and allocated on a consistent basis to individual lines, adjusted for State and reinsurance as necessary. The net investment income shall be reported consistent with the following bases, as appropriate to the member, adjusted for the individual health benefits plans for which the report is being made as necessary:

1. The NAIC Life and Health Blank (Blue), page 6, entitled "Analysis of Operations by Lines of Business," Column 11, line 4;

2. The NAIC Fire and Casualty Blank (Yellow), Insurance Expenses Exhibit, Part II, Column 18, line 15;

3. The NAIC HMDI Blank (White), page 4, Column 1, line 7, adjust for individual lines, reinsurance and Complementary Medicare;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 6; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Line 5.

11:20-8.6 Certification

(a) All reports shall be certified as accurate, complete and conforming with the requirements of this subchapter by the Chief Financial Officer or other duly authorized officer of the member. The person certifying the combined report of an affiliated carrier shall be the same person certifying the separate report of the member submitting the combined report for the affiliated carrier.

(b) Notwithstanding certification of the combined report, the persons certifying the separate reports of the members of the affiliated carrier shall be responsible for any errors contained in the separate member's report.

11:20-8.7 Failure to comply

(a) Failure to comply with the reporting provisions of this subchapter as required by June 28, 1993 shall result in:

1. The denial of a member's application for exemption from assessments for reimbursable losses under the IHC Program for the remainder of calendar year 1993; and

2. The Board***'s*** determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium base upon which that member's market share allocation of assessments for reimbursement of losses will be calculated by the Board.

SUBCHAPTER 9. EXEMPTIONS

11:20-9.1 Purpose

The purpose of this subchapter is to set forth the procedures for obtaining and the standards for granting exemptions from assessments for reimbursement of losses in accordance with N.J.S.A. 17B:27A-12.

11:20-9.2 Filing for an exemption from assessments for reimbursements

(a) A member seeking to be exempted from the obligation to pay assessments for the reimbursement of losses shall submit a written request for such exemption to the Board. A written request for an exemption shall be submitted annually no later than May 1, except that in 1993, written request for exemptions shall be submitted to the Board on or before August 1, 1993. ***No exemptions from assessments for 1992 losses will be granted.*** Written requests shall be submitted to:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

(b) Written requests for exemptions shall be certified by the Chief Financial Officer, or other duly authorized officer, of the member, and shall include affirmative statements that the member agrees:

1. To enroll or insure the minimum number of non-group persons necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20-93;

2. To enroll or insure the minimum number of non-group persons under:

i. Standard health benefit plans;

ii. Health benefits plans designed to meet the requirements for enrollment of Medicaid recipients and HealthStart Plus recipients, if such health benefits are ***offered and*** required to provide coverage not in compliance with the standard health benefits plans, pursuant to N.J.S.A. 30:4D-7b or 7c, or N.J.S.A. 26:2H-18.47, and any rules and regulations promulgated thereunder; and

iii. Medicare cost and risk contracts with the Federal government, with respect to Medicare recipients***, if offered***; and

3. Not to seek reimbursements for losses the member may incur under the standard health benefits plans in that calendar year for which an exemption is sought by the member.

(c) Within 30 days of receipt of the member's written request for an exemption, the Board shall grant the member a conditional exemption, or deny the member's request for an exemption in writing, specifying the reasons for the denial. If the member's written request for an exemption is neither approved nor disapproved within 30 days of its receipt by the Board, the written request shall be deemed to be conditionally approved.

(d) Approval of a member's written request for an exemption is conditioned upon the following:

1. Compliance by the member with N.J.A.C. 11:20-8 and this subchapter;

2. Compliance by the member with (b) above, as appropriate.

(e) Carriers denied a conditional exemption from assessments for reimbursements for losses may, within 20 days of the date of the Board's ruling, request a hearing, to be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. A request for a hearing shall include a detailed explanation of the reasons why the Board's decision should be reconsidered.

11:20-9.3 Minimum enrollment share

(a) On or about July 8, 1993, and annually thereafter on or before April 1, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that calendar year which the member must agree to cover in that calendar year for purposes of obtaining an exemption from assessments for reimbursements for losses incurred in that calendar year.

(b) The IHC Program Board's determination of minimum enrollment shares shall be based upon information provided by members in accordance with N.J.A.C. 11:20-8 and this subchapter.

(c) The minimum number of non-group persons shall be calculated as the total number of community rated and modified community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid and HealthStart Plus lives of all carriers subject to the Act as of the end of the preceding calendar year multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for the preceding calendar year including those carriers exempt from assessment.

11:20-9.4 Satisfaction of minimum number of non-group persons

(a) Persons counted under the following may be counted by a member in meeting its minimum number of non-group persons:

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1. Standard health benefits plans;
2. Conversion policies issued pursuant to the Act;
3. Contracts covering HealthStart Plus recipients; and
4. Medicare cost and risk contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's total number of non-group persons.

(b) If the member is a Federally-qualified HMO that is tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the Federal Internal Revenue Code of 1986, 26 U.S.C. 501, the member may count persons covered under (a)1 *[and]* ***through*** (a)4 above, except that in determining whether the member meets its minimum number of non-group persons, the total may include no more than one third Medicare recipients and one third Medicaid recipients.

11:20-9.5 Procedures for granting or denying exemptions

(a) A member granted a conditional exemption shall be granted a final exemption from assessments for reimbursements for losses accruing for the calendar year in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to N.J.A.C. 11:20-8 and this subchapter evidences the following:

1. By the end of calendar year 1993, the member has enrolled or insured at least 40 percent of the minimum number of non-group persons allocated to it by the Board;
2. By the end of calendar year 1994, the member has enrolled or insured at least 75 percent of the minimum number of non-group persons allocated to it by the Board; and
3. By the end of calendar year 1995 and thereafter in each calendar year, the member has enrolled or insured 100 percent of the minimum number of non-group persons allocated to it by the Board.

(b) Members receiving final exemptions from the Board shall not be liable for any portion of any assessments for reimbursements for losses for the calendar year for which the final exemption is granted. The Board shall determine, in writing, whether the member is granted a final exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for the preceding calendar year.

1. A member granted a conditional exemption that enrolls or insures fewer than the minimum number of non-group persons allocated to it by the Board shall be liable for a pro rata exemption from assessments for reimbursements for losses based upon the percentage of the minimum number of non-group persons actually enrolled or insured by the member, subject to a demonstration by the member in writing to the Board that the member has made a good faith effort to enroll or insure the minimum number of non-group persons allocated to it by the Board.

2. If the Board finds that the member has not made a good faith effort to enroll or insure its minimum number of non-group persons, the Board shall not grant a pro rata exemption to the member. The Board shall notify the member in writing as to its reasons for not granting the member a pro rata exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for the preceding calendar year.

(c) Members denied a pro rata exemption from assessments for reimbursements for losses may, within 20 days of the date of the Board's ruling, request a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. A request for a hearing shall include a detailed explanation of the reasons why the Board's action should be reconsidered.

(d) A member requesting a hearing by the Board shall remain liable for the full amount of any assessments for reimbursements for losses issued to it by the Board, until and unless the Board makes a finding that the member is liable for a pro rata assessment only, including any interest that may accrue.

(e) Members granted final exemptions or pro rata exemptions shall not be liable for any amount of reimbursements for losses which remain unreimbursed in accordance with N.J.S.A. 17B:27A-12e.

APPENDIX

EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for a BASIC health benefits plan.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
BASIC HEALTH BENEFITS PLAN
(New Jersey BASIC Health Benefits Plan)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey BASIC Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page 21.

All nouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.]

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the child reached this Policy's age limit;
  (3) the Child became insured before the child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the child's support and maintenance.

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In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

*[**HOSPICE.** A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.]*

***HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:**

(a) approved for its stated purpose by Medicare; or
(b) accredited for its stated purpose by the Joint Commission.*

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital.

A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result

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in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, destrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

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SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherpay—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Benefits Plan that provides the same or similar coverage and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of his eligibility.

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Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent*'s* becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM.

FACILITY BENEFIT—30 days Inpatient Hospital care.

FACILITY COINSURANCE—20% up to a maximum of $5000/Covered Person *[(then 100%, up to 30 days)]* ***100% after 30 days)***.

DOCTORS' SERVICES—50% Inpatient and Outpatient (incl. Surgery, anesthesia, radiology and obstetrics).

CASH DEDUCTIBLES:

INPATIENT (separate)—$1000/admission/Covered Person; max. of two Inpatient Deductibles/Covered Person.

OTHER COVERED CHARGES—$250/Covered Person, $500/family.

EMERGENCY ROOM—We will only pay $50/visit/Covered Person.

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Primary Care Services are not subject to Deductibles and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage	[$]
For Parent and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Policyholder and Spouse	[$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: For Inpatient Hospital services and supplies ***and Rehabilitation Center services and supplies not immediately preceded by an Inpatient Hospital Stay.*** You must pay one Inpatient Deductible per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. However, a Covered Person must satisfy two Inpatient Deductibles per Benefit Period. And all charges must be incurred while You are insured by this Policy. What We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family aggregate deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once the family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Inpatient Hospital Coinsurance amounts You must pay. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the Inpatient Hospital benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD. HOWEVER, A COVERED PERSON WILL RECEIVE CREDIT FOR ANY INPATIENT DEDUCTIBLE SATISFIED DURING A PERIOD OF CONFINEMENT PRECEDING A NEW BENEFIT PERIOD.

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Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan which provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE HOSPITAL ADMISSION REVIEW PROGRAM IN THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless he is a Dependent.

Blood: We cover Inpatient blood transfusions only.

Daily Room and Board Limits:
(During a Period of Hospital Confinement)

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Doctor Charges for Nonsurgical Care and Treatment: We only cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury under Primary Care Services. See the "Schedule of Benefits" and "Primary Care Services" sections of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover charges for cosmetic Surgery.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan on the basis of two Home Health Care days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as:

(a) Skilled Nursing Care furnished by or under the supervision of a registered Nurse;
(b) Therapy Services;
(c) Medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility;
(b) the services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by your Doctor within 14 days after home health care starts;
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy on the basis of two Inpatient Hospice days in exchange for each Inpatient Hospital day relinquished. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery. However, We do not cover specialist consultations in a Hospital.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if:

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(a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Rehabilitation Center: Subject to our advance written approval, when rehabilitation care can take the place of Inpatient care in a Hospital, We cover such care furnished to You in a Rehabilitation Center on the basis of two Rehabilitation Center days in exchange for each Inpatient Hospital day relinquished. We will pay for two Rehabilitation Center days in exchange for each Inpatient Hospital day relinquished, per Benefit Period. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second (or third) opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, when Skilled Nursing Care can take the place of Inpatient care, We cover such care furnished to You in a Skilled Nursing Center on the basis of two Skilled Nursing Center days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Therapy Services: We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But we do not cover Dialysis Treatment.

X-Rays and Laboratory Tests: We cover Inpatient and Outpatient x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. *[And We waive this limitation for Your Pre-Existing Condition to the extent that the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, In other words, where there was no gap in coverage.]* ***We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.***

Primary Care Services: We will cover up to $100 per Covered Person per Benefit Period, up to a maximum of $300 per family per Benefit Period, for routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

- Adenoidectomy
- Arthroscopy
- Bunionectomy
- Carpal Tunnel Surgery
- Cesarean Section
- Cholecystectomy
- Coronary Artery Angioplasty
- Coronary Artery Bypass Graft
- Esophagoscopy
- Excision of Intervertebral Disk
- Gastroduodenoscopy
- Hip Replacement
- Human Organ/Bone Marrow Transplant
- Hysterectomy
- Knee Replacement
- Lower Back Surgery
- Mastectomy
- Meniscectomy
- Myringotomy
- Pacemaker Implantation
- Prostatectomy
- Rhinoplasty
- Septectomy with Rhinoplasty
- Tonsillectomy
- Transplants
- Tubal Transection and/or Ligation
- Tympanoplasty
- Tympanostomy Tube

MEDICAL PROCEDURES

- Lower Back Medical Care
- CAT Scan
- Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

- Cardiac Catheterization
- Cystoscopy

OTHER SERVICES AND SUPPLIES

- Home Health Care
- Skilled Nursing Care
- Hospice Care
- Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

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Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Alcoholism.

Ambulance—air, water, ground and rail.

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Dialysis treatment.

Durable Medical Equipment.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations ***to determine the need for (or changes of) eyeglasses or lenses of any type***; eyeglasses, contact lenses, and all fittings, except as ***otherwise*** specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, *[hearing examinations or fitting of hearing aids]* ***and hearing exams to determine the need for hearing aids or the need to adjust them***.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury *[which occurred on the job or]* which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Mental or Nervous Conditions.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Outpatient Prescription Drugs.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;

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—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States, except in the case of a medical emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to Your treatment (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Substance Abuse.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, and non-human organ transplants.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or

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get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when we coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) *[cancellation or amendment by the Board of this basic health benefits plan.]* ***non-renewal as authorized by the Board.***

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a *[Child]* ***Dependent*** at 12:01 a.m. on the date the *[Child]* ***Dependent*** *[attains the Policy's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment]* ***loses eligibility***.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

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A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always

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secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT B

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan B.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN B
(New Jersey Individual Health Benefits Plan B)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan B.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page —.

All pronouns in the singular used in this Policy will be deemed to include plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

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BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:
(a) it carries out its stated purpose under all relevant state and local laws; or
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or your legally adopted child, and Your Stepchild if the child depends on You for most of the child's support and maintenance, Your step-child. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
(a) Your:
(1) Spouse;
(2) unmarried Child who is under age 20;
(3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before he reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective

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and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

*[**HOSPICE.** A facility which mainly provides Inpatient care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.]*

***HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:**

(a) approved for its stated purpose by Medicare; or
(b) accredited for its stated purpose by the Joint Commission.*

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital. A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

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(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for the majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.
(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:
(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

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THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent*'s* becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO PER LIFETIME MAXIMUM OF $1,000,000.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—40%.

OTHER COVERED CHARGES—40% up to $3,000/Covered Person, $6,000/family.

COINSURANCE CAP—After $3,000/Covered Person, $6,000/family, We pay 100%.

CASH DEDUCTIBLES:

INPATIENT (separate)—$200/day for the first 5 days of Inpatient Hospital care up to $1,000/admission/Covered Person for two admissions/Benefit Period.

OTHER COVERED CHARGES—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family. This Deductible is in addition to the Inpatient Deductible.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—365 days, if preapproved.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE—180 days/Covered Person, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

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NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.
(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: For Inpatient Hospital services ***and Rehabilitation Center services not immediately preceded by an Inpatient Hospital Stay*** You must pay an Inpatient Deductible, up to two per Benefit Period, per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Inpatient Hospital Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the Inpatient Hospital benefit.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD. HOWEVER, A COVERED PERSON WILL RECEIVE CREDIT FOR ANY INPATIENT HOSPITAL DEDUCTIBLE SATISFIED DURING A PERIOD OF CONFINEMENT PRECEDING A NEW BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your

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pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits:
During a Period of Hospital Confinement

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility.
(b) The services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per Benefit Period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including, but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second

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opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. *[And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.]* ***We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.***

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

- Adenoidectomy
- Arthroscopy
- Bunionectomy
- Carpal Tunnel Surgery
- Cesarean Section
- Cholecystectomy
- Coronary Artery Angioplasty
- Coronary Artery Bypass Graft
- Esophagoscopy
- Excision of Intervertebral Disk
- Gastroduodenoscopy
- Hip Replacement
- Human Organ/Bone Marrow Transplants
- Hysterectomy
- Knee Replacement
- Lower Back Surgery
- Mastectomy
- Meniscectomy
- Myringotomy
- Pacemaker Implantation
- Prostatectomy
- Rhinoplasty
- Septectomy with Rhinoplasty
- Tonsillectomy
- Transplants
- Tubal Transection and/or Ligation
- Tympanoplasty
- Tympanostomy Tube

MEDICAL PROCEDURES

- Lower Back Medical Care
- CAT Scan
- Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

- Cardiac Catheterization
- Cystoscopy

OTHER SERVICES AND SUPPLIES

- Home Health Care
- Hospice Care
- Skilled Nursing Care
- Durable Medical Equipment
- Private Duty Nursing
- Prosthetics
- Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures,**

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services and supplies You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND THOSE CHARGES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services and supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations ***to determine the need for (or changes of) eyeglasses or lenses of any type***; eyeglasses, contact lenses, and all fittings, except as ***otherwise*** specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids*[, hearing examinations or fitting of hearing aids.]* ***and hearing exams to determine the need for hearing aids or the need to adjust them.***

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury *[which occurred on the job or]* which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for services;

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—for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States, except in the case of a medical emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex harmones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or

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medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan that provides the same or similar coverage;
(e) *[cancellation or amendment by the Board of this individual health benefits plan]* ***non-renewal as authorized by the Board***.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a *[Child]* ***Dependent*** at 12:01 a.m. on the date the *[Child]* ***Dependent*** *[attains the Policy's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment]* ***loses eligibility***.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

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[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

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This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT C

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan C.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN C
(New Jersey Individual Health Benefits Plan C)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan C.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page —.

All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of Illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charges. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

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BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:
(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
(a) Your:
(1) Spouse;
(2) unmarried Child who is under age 20;
(3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

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Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

*[**HOSPICE.** A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.]*

***HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:**

(a) approved for its stated purpose by Medicare; or
(b) accredited for its stated purpose by the Joint Commission.*

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital. A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

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OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

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Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent*'s* becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—30%.

OTHER COVERED CHARGES—30% up to $2,500/Covered Person, $5,000/family.

COINSURANCE CAP—After $2,500/Covered Person, $5,000/family, We pay 100%.

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—180 days/Covered Person, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

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IV. PREMIUM RATES AND PROVISIONS

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.
(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of the Policy called "Exclusions."

Daily Room and Board Limits
During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

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Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility.
(b) The services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per Benefit Period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs if You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including, but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance

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Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 30% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. *[And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.]* ***We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.***

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

- Adenoidectomy
- Arthroscopy
- Bunionectomy
- Carpal Tunnel Surgery
- Cesarean Section
- Cholecystectomy
- Coronary Artery Angioplasty
- Coronary Artery Bypass Graft
- Esophagoscopy
- Excision of Intervertebral Disk
- Gastroduodenoscopy
- Hip Replacement
- Human Organ/Bone Marrow Transplants
- Hysterectomy
- Knee Replacement
- Lower Back Surgery
- Mastectomy
- Meniscectomy
- Myringotomy
- Pacemaker Implantation
- Prostatectomy
- Rhinoplasty
- Septectomy with Rhinoplasty
- Tonsillectomy
- Transplants
- Tubal Transection and/or Ligation
- Tympanoplasty
- Tympanostomy Tube

MEDICAL PROCEDURES

- Lower Back Medical Care
- CAT Scan
- Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

- Cardiac Catheterization
- Cystoscopy

OTHER SERVICES AND SUPPLIES

- Home Health Care
- Hospice Care
- Skilled Nursing Care
- Durable Medical Equipment
- Private Duty Nursing
- Prosthetics
- Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services and supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

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STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations ***to determine the need for (or changes of) eyeglasses or lenses of any type***; eyeglasses, contact lenses, and all fittings, except as ***otherwise*** specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids*[, hearing examinations or fitting of hearing aids]* ***and hearing exams to determine the need for hearing aids or the need to adjust them***.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury *[which occurred on the job or]* which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a

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Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States, except in the case of a Medical Emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex harmones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

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Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) *[cancellation or amendment by the Board of this individual health benefit plan]* ***non-renewal as authorized by the Board***.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a *[Child]* ***Dependent*** at 12:01 a.m. on the date the *[Child]* ***Dependent*** *[attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment]* ***loses eligibility***.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

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[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

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CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT D

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan D.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN D
(New Jersey Individual Health Benefits Plan D)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan D.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page —.

All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and

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(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that you submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food

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and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

*[**HOSPICE.** A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.]*

***HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:**

(a) approved for its stated purpose by Medicare; or
(b) accredited for its stated purpose by the Joint Commission.*

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital. A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential

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psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, destrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.
(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:
(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

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Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent*'s* becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—20% up to $2,000/Covered Person, $4,000/family.

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—180 days/Covered Person, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first years of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

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We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE HOSPITAL ADMISSION REVIEW PROGRAM IN THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits:

During a Period of Hospital Confinement

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

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Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility;
(b) the services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by Your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days;
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per benefit period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Doctor charges for a second opinion and
charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called

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"Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. *[And We waive this limitation for Your Pre-Existing Condition to the extent that the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.]* ***We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.***

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

- Adenoidectomy
- Arthroscopy
- Bunionectomy
- Carpal Tunnel Surgery
- Cesarean Section
- Cholecystectomy
- Coronary Artery Angioplasty
- Coronary Artery Bypass Graft
- Esophagoscopy
- Excision of Intervertebral Disk
- Gastroduodenoscopy
- Hip Replacement
- Human Organ/Bone Marrow Transplants
- Hysterectomy
- Knee Replacement
- Lower Back Surgery
- Mastectomy
- Meniscectomy
- Myringotomy
- Pacemaker Implantation
- Prostatectomy
- Rhinoplasty
- Septectomy with Rhinoplasty
- Tonsillectomy
- Transplants
- Tubal Transection and/or Ligation
- Tympanoplasty
- Tympanostomy Tube

MEDICAL PROCEDURES

- Lower Back Medical Care
- CAT Scan
- Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

- Cardiac Catheterization
- Cystoscopy

OTHER SERVICES AND SUPPLIES

- Home Health Care
- Hospice Care
- Skilled Nursing Care
- Durable Medical Equipment
- Private Duty Nursing
- Prosthetics
- Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We

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will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations ***to determine the need for (or changes of) eyeglasses or lenses of any type***; eyeglasses, contact lenses, and all fittings, except as ***otherwise*** specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids*[, hearing examinations or fitting of hearing aids]* ***and hearing exams to determine the need for hearing aids or the need to adjust them***.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury *[which occurred on the job or]* which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;

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—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Substance Abuse.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the recognized Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Coveraged Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

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XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 A.M. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, his eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) *[cancellation or amendment by the Board of this individual health benefit plan]* ***non-renewal as authorized by the Board***.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a *[Child]* ***Dependent*** at 12:01 a.m. on the date the *[Child]* ***Dependent*** *[attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment]* ***loses eligibility***.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

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A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is

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automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT E

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan E.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN E
(New Jersey Individual Health Benefits Plan E)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan E.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page —.

All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of Illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charges. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

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We will recognize it if:
(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:
(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:
(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
(a) Your:
(1) Spouse;
(2) unmarried Child who is under age 20;
(3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:
1. any medical device, drug, or biological product must have received final approval to market by the United States Food and

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Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

*[**HOSPICE.** A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.]*

***HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:**

(a) approved for its stated purpose by Medicare; or
(b) accredited for its stated purpose by the Joint Commission.*

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital. A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential

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psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for the majority of a Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

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Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent*'s* becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—10% up to $1,500/Covered Person, $3,000/family.

COINSURANCE CAP—After $1,500/Covered Person, $3,000/family, We pay 100%.

CASH DEDUCTIBLES—[$150] [$500] [$1,000]/Covered Person, [$300] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductibles or Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]

For Parent and Child(ren) Coverage ..... [$]

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For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.
(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan which provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits:
During a Period of Hospital Confinement

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

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Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) Medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility;
(b) the services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days.
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per Benefit Period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including:

(a) any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called

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"Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. *[And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.]* ***We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.***

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

- Adenoidectomy
- Arthroscopy
- Bunionectomy
- Carpal Tunnel Surgery
- Cesarean Section
- Cholecystectomy
- Coronary Artery Angioplasty
- Coronary Artery Bypass Graft
- Esophagoscopy
- Excision of Intervertebral Disk
- Gastroduodenoscopy
- Hip Replacement
- Human Organ/Bone Marrow Transplants
- Hysterectomy
- Knee Replacement
- Lower Back Surgery
- Mastectomy
- Meniscectomy
- Myringotomy
- Pacemaker Implantation
- Prostatectomy
- Rhinoplasty
- Septectomy with Rhinoplasty
- Tonsillectomy
- Transplants
- Tubal Transection and/or Ligation
- Tympanoplasty
- Tympanostomy Tube

MEDICAL PROCEDURES

- Lower Back Medical Care
- CAT Scan
- Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

- Cardiac Catheterization
- Cystoscopy

OTHER SERVICES AND SUPPLIES

- Home Health Care
- Hospice Care
- Skilled Nursing Care
- Durable Medical Equipment
- Private Duty Nursing
- Prosthetics
- Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We

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will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations ***to determine the need for (or changes of) eyeglasses or lenses of any type***; eyeglasses, contact lenses, and all fittings, except as ***otherwise*** specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids*[, hearing examinations or fitting of hearing aids]* ***and hearing exams to determine the need for hearing aids or the need to adjust them***.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury *[which occurred on the job or]* which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;

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—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

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XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 A.M. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, his eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) *[cancellation or amendment by the Board of this individual health benefit plan]* ***non-renewal as authorized by the Board***.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a *[Child]* ***Dependent*** at 12:01 a.m. on the date the *[Child]* ***Dependent*** *[attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment]* ***loses eligibility***.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

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Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

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GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT F

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
HEALTH MAINTENANCE ORGANIZATION BENEFITS PLAN
(New Jersey HMO Health Benefits Plan)

Policy Term. The Policy takes effect on _____ , the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid or a Group Health Benefits Plan. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Premiums. We may only change the Premium**s** *[schedule]* for this Policy if We change the Premium**s** *[schedule]* for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this HMO Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand what services are provided. Information about the services provided under this Policy begins on page —.

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured.

BIRTHING CENTER. A facility which mainly provides care and treatment for people during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

[We will recognize it if] ***It must also***:

(a) *[it carries]* ***carry*** out its stated purpose under all relevant state and local laws; or
(b) *[it is]* ***be*** approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) *[it is]* ***be*** approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CHILD. Your own issue or your legally adopted child and, if he depends on You for most of his support and maintenance, Your stepchild. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom you have legal custody or legal guardianship is considered a Child under this Policy. (We may require that you submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or the Policyholder's Spouse is not a Child for purposes of eligibility for services under this Policy.

[**COINSURANCE.** The percentage of a Covered Services or Supplies that must be paid by You. Coinsurance does not include Copayments or Non-Covered Expenses.]

COPAYMENT. A specified dollar amount which You must pay for certain Covered Services or Supplies.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Policy. The services and supplies must be:

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(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

Read the entire Policy to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:
(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
(a) Your:
(1) Spouse;
(2) unmarried Child who is under age 20;
(3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask You to provide periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to support itself;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until the Child reached such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
(b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:
1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. *[We will recognize it if it]* ***It*** is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

*[**HOSPICE.** A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

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(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.]*

***HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:**

(a) approved for its stated purpose by Medicare; or

(b) accredited for its stated purpose by the Joint Commission.*

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. *[We will recognize it if it]* ***It*** carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers ***or Alcoholics*** is not a Hospital.

A specialty facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under this Policy.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us to provide Covered Services or Supplies.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Copayments and Coinsurance are also Non-covered Expenses.

[NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
(b) provides medical services which are within the scope of the nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are registered at a recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Member who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the exclusions section of this Policy for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a Doctor specializing in family practice, general practice,

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internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIMARY RESIDENCE. The location where You reside for a majority of the *[Benefit Period]* ***Calendar Year*** with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey. *[A temporary absence may not exceed three months out of each Benefit Period.]*

PROVIDER. A recognized facility or practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician that directs You to a facility or Provider for health care.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. *[We will recognize it if it]* ***It*** carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. *[We will recognize it if it]* ***It*** carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPECIALIST DOCTOR. A Doctor who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

[We will recognize it if it] ***It*** carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependent(s).
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

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WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for a Group Health Benefits Plan, Medicare or Medicaid.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of the Child's eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child*'s* becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent*'s* becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF SERVICES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS POLICY ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER BENEFIT PERIOD, UNLESS OTHERWISE STATED. *BENEFITS ARE PER MEMBER, AND MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.*

FACILITY BENEFIT—Unlimited days.

COPAYMENTS:

HOSPITAL SERVICES:

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period.

OUTPATIENT—$15 Copayment/visit.

DOCTOR SERVICES:

INPATIENT—None.

OUTPATIENT—$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM—$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours ***as a result of the emergency***).

ALCOHOLISM:

OUTPATIENT—$15 Copayment/visit for a maximum of 20 visits/Benefit Period.

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period. Maximum of 30 days Inpatient care/Benefit Period. One Inpatient day may be exchanged for two Outpatient visits.

AMBULATORY SURGERY—$15 Copayment/visit.

BIRTHING CENTERS—$15 Copayment/visit.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CHARGES—Unlimited days, if preapproved.

MATERNITY (PRE-NATAL CARE)—$25 Copayment/initial visit.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE:

OUTPATIENT—$15 Copayment/visit for a maximum of 20 visits/Benefit Period.

INPATIENT—$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Benefit Period. Maximum of 30 days Inpatient care/Benefit Period. One Inpatient day may be exchanged for two Outpatient visits.

PODIATRIC—$15 Copayment/visit (excludes Routine Foot Care).

PRE-ADMISSION TESTING—$15 Copayment/visit.

PRESCRIPTION DRUG—50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES—$15 Copayment/visit.

PRIMARY CARE SERVICES—$15 Copayment/visit.

REHABILITATION CENTER—Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if the Admission is immediately preceded by a Hospital Inpatient Stay.

SECOND SURGICAL OPINION—$15 Copayment/visit.

SPECIALIST SERVICES—$15 Copayment/visit. *[You must have a Referral from Your Primary Care Physician.]*

SKILLED NURSING CARE—Unlimited days, if preapproved.

THERAPY SERVICES—$15 Copayment/visit.

X-RAY & LAB (OUTPATIENT)—$15 Copayment/visit.

NOTE: NO BENEFITS WILL BE PROVIDED IF YOU FAIL TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH YOUR PRIMARY CARE PHYSICIAN. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The [monthly] premium rates, in U.S. dollars, for the coverage provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Member that was included in the Premiums paid for the two-month period immediately before the date the Member's coverage has ended.

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(b) the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Policy. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. COVERED SERVICES

You are entitled to receive the benefits in the following sections when Medically Necessary, subject to the payment by you of applicable copayments as stated in the applicable Schedule of Benefits.

(a) **OUTPATIENT BENEFITS.** The following services are covered only at the Primary Care Physician's office selected by you, or elsewhere upon prior written referral by Your Primary Care Physician:
  1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
  2. **Home visits** by your Primary Care Physician.
  3. **Periodic health examinations** to include:
     a. Well child care from birth including immunizations;
     b. Routine physical examinations, including eye examinations;
     c. Routine gynecologic exams and related services;
     d. Routine ear and hearing examination; and
     e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of your employment).
  4. **Diagnostic Services.**
  5. **Casts and dressings.**
  6. **Ambulance Service** when certified in writing as Medically Necessary by your Primary Care Physician and approved in advance by Us.
  7. **Infertility Services** except where specifically excluded in this Policy.
  8. **Prosthetic Devices and Durable Medical Equipment** when ordered by your Primary Care Physician and arranged through Us. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements, repairs, wigs, or dental prosthetics or devices.
  9. **Prescription Drugs.**

(b) **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the Doctor's office or at a Participating Hospital outpatient department during office or business hours upon prior written referral by your Primary Care Physician. Services include but are not limited to the following:
  1. Allergy (except serum injections which are covered when administered by your Primary Care Physician)
  2. Anesthesia
  3. Cardiology
  4. Endocrinology
  5. Gynecology and Obstetrics
  6. Internal Medicine
  7. Neurology
  8. Oncology
  9. Ophthalmology
  10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other HMO-approved surgical procedures)
  11. Orthopedics
  12. Otolaryngology
  13. Pathology
  14. Pediatrics
  15. Podiatry
  16. Pulmonology
  17. Radiology (except dental x-rays, unless related to Covered Services)
  18. Surgery
  19. Urology

(c) **INPATIENT HOSPITAL*, REHABILITATION CENTER*** & SKILLED NURSING CENTER BENEFITS. The following Services are covered when hospitalized by a Participating Doctor upon prior written referral from your Primary Care Physician, only at Participating Hospitals and Participating Providers (or at non-participating facilities upon prior written authorization by us); however, Participating Skilled Nursing Center benefits are limited to those which are Medically Necessary and which constitute Skilled Nursing Care:
  1. Semi-private room and board accommodations
  2. Private accommodations will be provided only when Medically Necessary as certified by your attending physician in concurrence with your Primary Care Physician and approved in advance by Us. If you occupy a private room without such certification you shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospital or the Participating Skilled Nursing Center and the private room rate.
  3. General nursing care
  4. Use of intensive or special care facilities
  5. X-ray examinations including CAT scans but not dental x-rays
  6. Use of operating room and related facilities
  7. Magnetic resonance imaging
  8. Drugs, medications, biologicals
  9. Cardiography/Encephalography
  10. Laboratory testing and services
  11. Pre- and post-operative care
  12. Special tests
  13. Nuclear medicine
  14. Therapy Services
  15. Oxygen and oxygen therapy
  16. Anesthesia and anesthesia services
  17. Blood, blood products and blood processing
  18. Intravenous injections and solutions
  19. Surgical, medical and obstetrical services
  20. Private duty nursing only when Medically Necessary as certified by the Participating Specialist Physician or other attending physician in concurrence with your Primary Care Physician and approved in advance by Us.
  21. The following transplants, when Medically Necessary: Cornea, Kidney, Lung, Liver, Heart, Pancreas, and Bone Marrow (for the treatment of Leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders (SCID and WISCOT Alldrich)).

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center upon prior written referral by your Primary Care Physician.
  1. **Outpatient.** You are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days.

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Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by your Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by your Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

   Chemical Dependency Admissions. Repeated detoxification treatment for chronic substance abuse will not be covered unless in our sole discretion it is determined that You have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of substance abuse services.

3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and only to the extent of the covered benefit as defined above.

(e) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center upon prior written referral by your Primary Care Physician.

1. **Outpatient.** You are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical treatment and medical referral services by your Primary Care Physician for the abuse of or addiction to alcohol. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by your Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, and referral services for substance abuse or addiction. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

   Detoxification Admissions. Repeated detoxification treatment for chronic alcoholism will not be covered unless in our sole discretion it is determined that You have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of alcoholism services.

3. Court-ordered alcohol admissions are not covered unless Medically Necessary and only to the extent of the covered benefit as defined above.

(f) ***MEDICAL* EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by your Primary Care Physician in the event of an Emergency as determined by *[us]* ***Us***.

1. Your Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to your health, you shall call your Primary Care Physician prior to seeking emergency treatment.

2. We will cover the cost of *[emergency medical]* ***Medical Emergency*** and hospital services performed within or outside our service area without a prior written referral only if:

   a. Our review determines that your symptoms were severe and delay of treatment would have been detrimental to your health, the symptoms occurred suddenly, and you sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
      1. uncontrolled or excessive bleeding
      2. acute pain or conditions requiring immediate attention, such as suspected heart attack, severe shortness of breath or appendicitis
      3. serious burns
      4. poisoning
      5. convulsions
      6. unconsciousness

      A near-term delivery is not a Medical Emergency.

   b. The service rendered is provided as a benefit under this Policy and is not a service which is normally treated on a non-emergency basis; and

   c. We and your Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. You shall be responsible for payment for services received unless We determine that your failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3. In the event you are hospitalized in a *[non]***Non***-participating facility, coverage will only be provided until You are medically able to travel or to be transported to a Participating facility. If You elect to continue treatment with Non-participating providers, We shall have no responsibility for payment beyond the date You are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary ***and Appropriate***, We will cover the reasonable cost as determined by us. Reimbursement may be subject to payment by you of all copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to Participating Provider.

4. Coverage for emergency services includes only such treatment necessary to treat the *[emergency]* ***Medical Emergency***. Any elective procedures performed after You have been admitted to a facility as the result of *[an emergency]* ***a Medical Emergency*** shall require prior written referral or You shall be responsible for payment.

5. The copayment for an emergency room visit will not apply in the event that You were referred for such visit by your Primary Care Physician for services that could have been rendered in the Primary Care Physician's office or if You are admitted as an inpatient to the hospital as a result of the *[emergency]* ***Medical Emergency***.

(h) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by your Primary Care Physician.

1. Speech therapy, Physical therapy, occupational therapy and cognitive therapies are covered for non-chronic conditions and acute illnesses and injuries upon referral to a Participating Provider by your Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of illness or injury, beginning with the first day of treatment, provided that your Primary Care Physician certifies in writing that the treatment will result in a significant improvement of your condition within this time period and treatment is approved in writing by Us.

2. Chelation therapy, chemotherapy treatment, dialysis treatment, infusion therapy and radiation therapy.

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(i) **HOME HEALTH BENEFITS.** The following Services are covered when rendered by a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by us upon the prior referral of your Primary Care Physician.

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to you is skilled in nature.
3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of your medical condition.
4. Therapy Services as set forth above.
5. Hospice Care if You are terminally ill with life expectancy of six months or less. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

VI. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY.

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Any service provided without prior written Referral by the Member's Primary Care Physician except as specified in this Policy.

Any therapy not included in Our definition of Therapy Services.

[Artificial and surgical drugs and procedures] ***Artificial drugs and surgical procedures*** designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations ***to determine the need for (or changes of) eyeglasses or lenses of any type***; eyeglasses, contact lenses, and all fittings, except as ***otherwise*** specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider *[that is not an eligible facility]* ***unless You were referred to the Provider by Your Primary Care Physician***.

Fluoroscopy or x-ray examinations without film.

Hearing aids*[, hearing examinations or fitting of hearing aids]* ***and hearing exams to determine the need for hearing aids or the need to adjust them***.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury *[which occurred on the job or]* which is covered or could have been covered for services provided under workers' compensation, employer's liability, occupational disease or similar law.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. *[And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before the Your coverage under this Policy started, i.e., no intervening lapse in coverage.]* ***We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.***

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —needed because You committed or tried to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of his normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate;
- —***for*** which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

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Special medical reports not directly related to treatment of the Member (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Therapeutic Manipulations.

Transplants, unless otherwise specifically covered, and non-human organ transplants.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

VII. GRIEVANCE PROCEDURE

[**Grievance Procedure:** Variable by Carrier as approved by the State of New Jersey.]

VIII. COORDINATION OF BENEFITS

SERVICES AVAILABLE UNDER OTHER POLICIES

If Covered Services are provided under this Policy and these same Covered Services or expenses are covered under Other Valid Coverage, Our liability will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our liability on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the reasonable cash value of the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on an individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

IX. GENERAL PROVISIONS

AMENDMENT

The Policy may be amended, at any time, without Your consent or ***that*** of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by us ***or as may otherwise be provided by law***; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Policy or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

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IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Policy is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Policy, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Policyholder, coverage may be terminated for the Policyholder as well as any of the Policyholder's Dependents who are Members. To be eligible for services or benefits under this Policy, the holder of the card must be a Member on whose behalf all applicable premium charges under this Policy have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Policy shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by us, and all rights of such Member and his or her Dependents, if any, pursuant to this Policy shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Policy, or similar causes, the rendition of medical or hospital benefits or other services provided under this Policy is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any Participating Provider or other provider, institution, facility or agency.
2. Neither the Policyholder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Policy.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Policyholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by us.

MEDICAL NECESSITY

Members will receive designated benefits under the Policy only when Medically Necessary. We may determine whether any benefit provided under the Policy was Medically Necessary, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Policy that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Policy.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

POLICY INTERPRETATION

We shall administer Policy in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey within our authorized Service Area. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

REFERRAL FORMS

You can be referred for Specialist Services by Your Primary Care Physician.

You will be responsible for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor HMO, or any Participating Provider will have further responsibility to provide any of the benefits available under this Policy for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure. The foregoing is not applicable if such refusal is according to a properly executed *[Advance Directive]* ***advance directive or living will*** for medical treatment.

REPORTS AND RECORDS

HMO is entitled to receive from any provider of services to Member such information HMO deems is necessary to administer this Policy

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subject to all applicable confidentiality requirements as defined in this Policy. By accepting coverage under this Policy, Policyholder, for *[himself or herself]* ***the Policyholder***, and for all Dependents covered hereunder, authorizes each and every provider who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and *[physical]* ***medical*** condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician [or Health Center].

You select a Primary Care Physician from our Doctors Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Doctor. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

STATEMENTS

No statement will avoid the coverage, or be used in defense of a claim under this Policy, unless it is contained in writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a *[Child]* ***Dependent*** at 12:01 a.m. on the date the *[Child]* ***Dependent*** *[attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment]* ***loses eligibility***.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 A.M. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan;
(e) *[cancellation or amendment by the Board of this individual health benefit plan]* ***non-renewal as authorized by the Board***.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Members.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN

Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In a Medical Emergency, You may go directly to the emergency room. If You do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will *[provide]* ***cover*** services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage Your treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcoholism. You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

EXHIBIT G

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You *[and any family members whom you wish to cover]* must be ***a*** New Jersey resident*[s]*.
3. You and any family members you wish to cover must not be eligible to be covered or actually covered under:
   (a) a group health benefits plan that provides same or similar coverage for hospital and medical expenses;
   (b) Medicare; or
   (c) Medicaid.
4. Please note that benefits under this plan may be reduced if the benefits are also covered under another individual health benefits plan.
5. The effective date of your coverage shall be no later than the first of the month following the month in which the completed application was dated (and premium payment is received).

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INDIVIDUAL APPLICATION INSTRUCTIONS

COMPLETE ALL SECTIONS IF YOU ARE:

1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber].
2. Changing dependent coverage.

[COMPLETE SECTIONS 1, 2, 3, [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1—Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide sex, date of birth, and social security number for each individual listed. ***Note: Your social security number is for the use of the insurance carrier; the New Jersey Individual Health Coverage Board will not collect or use this information*** If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 20 or 23, as applicable, but is mentally or physically handicapped, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2—Complete all information.

Section 3—Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4—This information is required. Please complete all information.

[Section 5—From the appropriate directory, choose the location number for a primary physician [or Center] (required for **all** members), GYN (if applicable). Check the change block only if you are changing providers.]

Section [5/6]—Applicant **must sign** this section and date this form for any activity or it will not be processed.

Section [6/7]—This information may be supplied voluntarily. Check appropriate box.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by (carrier) after a review of the application [and receipt of payment].
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under twenty (20) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of twenty (20) and twenty-three (23) who are full-time students at an accredited educational institution and receive at least half of their support from applicant and/or applicant's spouse and neither applicant's spouse nor children are eligible for group health benefits coverage.
3. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Individual Contract.
4. The Individual Contract will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

[5. As a condition to benefits, applicant understands and agrees that (with the exception of emergency procedures as defined in the Individual Contract) all services, in order to be covered by (Carrier), must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician.]

[6. Applicant agrees to make payment directly to health care providers such copayments as are provided for in the Individual Contract.]

[7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Center], primary care physician or other health care provider.]

[8. Applicant acknowledges that (Carrier's) participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of (Carrier).]

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Please print in ink all information requested on this application.

1.	Eligible Persons to be Enrolled (Note: Dependent children may be covered under their parent's contract only while unmarried and until *[the end of the calendar year in which they reach age 20 or 23,]* ***they attain age 20 or 23,*** if full-time students. Unmarried *[and]* handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.

This section must be completed in its entirety.

LAST NAME	FIRST NAME	MI	BIRTHDATE MO	DAY	YR	SEX (M or F)	Social Security Number
Applicant 1. ☐ Add ☐ Remove							___/___/___-___/___-___/___/___
Spouse 2. ☐ Add ☐ Remove							___/___/___-___/___-___/___/___
Child 3. ☐ Add ☐ Remove							___/___/___-___/___-___/___/___
Child 4. ☐ Add ☐ Remove							___/___/___-___/___-___/___/___
Child 5. ☐ Add ☐ Remove							___/___/___-___/___-___/___/___

**Attach sheet to list additional children. Attach proof if full-time student. Totally disabled dependent children will be covered regardless of age. Attach proof of disability.*

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? ☐ Yes ☐ No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

_____

2. PRIMARY RESIDENCE

Street Apt. City State Zip

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: ☐ Home ☐ Work

Are you a resident of the State of New Jersey? ☐ Yes ☐ No

Do you maintain a residency in any other state? ☐ Yes ☐ No

If "Yes", (a) Name of state _____
(b) How much time do you spend there each year? _____

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3. COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY FAMILY) IN: *(Only one may be selected.)*

[PLAN A ( )
PLAN B ( ) Deductible $250 ____ $500 ____ $1000 ____
PLAN C ( ) Deductible $250 ____ $500 ____ $1000 ____
PLAN D ( ) Deductible $250 ____ $500 ____ $1000 ____
PLAN E ( ) Deductible $150 ____ $500 ____ $1000 ____]

[HMO Plan [$10] $15 [$20] copayment.]

Type of Contract: ☐ Single

[☐ Family]

[☐ Parent & Child(ren)]

[☐ Husband/Wife]

Type of Activity:

☐ New Subscriber

☐ Add/Remove Dependent
Reason _____
Date of Event _____

☐ Name Change From/To _____

[☐ Change of Primary or GYN]

☐ Withdrawal From Coverage
Date Of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

☐ Monthly ☐ Quarterly

4. OTHER HEALTH CARE COVERAGE (Please note that, in some situations, if you are eligible for other health benefits coverage, you are not eligible for this policy.)

Are you employed? ☐ Yes ☐ No	If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? *(i.e., coverage under your employer's health benefits coverage, Medicare or Medicaid)*	☐ Yes ☐ No
If yes, give name and policy no. of other carrier or type of coverage.	
Are other family members eligible for coverage? If yes, specify.	
Are you replacing existing coverage?	☐ Yes ☐ No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy.	

[5. PROVIDER SELECTION

		[CENTER] CHANGE	PRIMARY OFFICE NO.	GYN OFFICE NO.
Applicant	1.	☐		

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Spouse	2.	☐		
Child	3.	☐		
Child	4.	☐		
Child	5.	☐		

]

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to (carrier) for coverage for any eligible dependents listed above and myself.

I understand that for the 12 months following the effective date of this policy, benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this policy. (Note: This limitation may not apply if the eligible person transfers from another health benefits plan.)

[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, (carrier) may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to (carrier or its assignee) information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to (carrier or its assignee.)

I state that: (a) I am a resident of New Jersey, (b) the information given on this application is complete to the best of my knowledge and belief and (c) that (carrier) will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application (carrier) can cancel this contract as of the original effective date.

Applicant's Signature: _____ Date Signed: _____

Preparer's Signature: _____ DOI License # _____ Date Signed: _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [certificate][contract][policy]. It becomes part of your contract with us.

[6.][7.] INCOME HOUSEHOLD

You do not need to fill out this section. The information will be used for statistical purposes only, in a way that will not identify you personally. This information will not affect your application, acceptance or coverage.

☐ under $10,000 ☐ $20-30,000 ☐ $30-40,000 ☐ $40-50,000 ☐ $50 - $60,000

☐ $60,000 and above

IHCAS - 6/93

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EXHIBIT H

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

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EXHIBIT 1

1 | 2 | 3 PATIENT CONTROL NUMBER | 4 TYPE OF BILL

5 BC/BS PROV. NO | 6 FEDERAL TAX NO. | 7 MEDICARE NO. | 8 MEDICAID NO. | 9

10 PATIENT'S LAST NAME | FIRST NAME | INITIAL | 11 PATIENT'S ADDRESS | CITY | STATE | ZIP

12 BIRTH DATE | 13 SEX | 14 MS | ADMISSION 15 DATE | 16 HR. | 17 TYPE | 18 SRC | 19 A.H | 20 D.H. | 21 STAT. | 22 STATEMENT COVERS PERIOD FROM THROUGH | 23 COV D. | 24 N.C.D. | 25 C.4 D. | 26 L.R.D. | 27

28 OCCURRENCE CD DATE | 29 OCCURRENCE CD DATE | 30 OCCURRENCE CD DATE | 31 OCCURRENCE CD DATE | 32 OCCURRENCE CD DATE | 33 OCCURRENCE SPAN CD FROM THROUGH

34 | CONDITION CODES 35 36 37 38 39 | BLOOD RECORD (PINTS) 40 FURN 41 REPL 42 NOT RP 43 DED. | 44 S.P. PROC. | 45

46 VALUE CD AMT | 47 VALUE CD AMT | 48 VALUE CD AMT | 49 VALUE CD AMT

a
b

50 DESCRIPTION | 51 R CODE | 52 S UNITS | 53 TOTAL CHARGES | 54 | 55 | 56

57 PAYER | 58 REL INFO | 59 ASG BEN | 60 DEDUCTIBLE | 61 CO-INSURANCE | 62 EST. RESPONSIBILITY | 63 PRIOR PAYMENTS | 64 EST. AMOUNT DUE

A
B
C

DUE FROM PATIENT ▶

65 INSURED'S NAME | 66 SEX | 67 P.REL. | 68 CERT.-SSN-HIC-ID NO. | 69 GROUP NAME | 70 INSURANCE GROUP NO.

A
B
C

71 EID | 72 ESC | 73 EMPLOYER NAME | 74 EMPLOYEE ID | 75 EMPLOYER LOCATION

NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

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EXHIBIT J

Loss Ratio Report Form

New Jersey Individual Health Coverage Program

Calendar Year Ending December 31, _____

*Name of Carrier: _____ NAIC # _____

Address: _____

_____

*A separate Report Form should be completed and filed for each affiliate.

A. Net Earned Premium for Standard Health Benefits Plans $_____

B. Losses

1. Claims incurred during calendar year and paid through June 30, _____ $_____
2. Residual Reserve (a or b)
   a. Safeharbor reserve (3.3% of B1) $_____
   b. Calculated residual reserve (enclose required actuarial certification) $_____
3. Pro rata share of assessments $_____
4. Total Losses (Either 1 + 2a + 3 or 1 + 2b + 3) $_____

C. Loss Ratio (B ÷ A) _____%

If C is less than 75%, then a plan must be included for returns of the difference to policy and contract holders.

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 17B:27A-9e(1) and (2) and N.J.A.C. 11:20-7.

_____ Date

_____ Actuary's Signature

_____ Title

_____ Telephone Number

EXHIBIT K

New Jersey Individual Health Coverage Program
Carrier Market Share and Net Paid Loss Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. In 1993 Reports must be completed and returned on or before June 28, 1993. Thereafter, Reports must be completed and returned on or before March 1 annually. Completed Reports must be returned to:

Interim Administrator, IHC Program
c/o The Prudential Insurance Co. of America
P.O. Box 4080
Iselin, NJ 08830

Fax number (908) 632-7409.

Part A. Carrier Information

1. Carrier's Name: _____
2. Carrier's NAIC Number (including Group): _____
3. Is the specifically-named Carrier an affiliated Carrier?

   _____ Yes _____ No

   a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically-named Carrier?

      _____ All Affiliated Carriers' combined Report
      _____ Specifically-named Carrier's separate Report

   b. If for all Affiliated Carriers, indicate the number of specifically-named Carrier Reports attached to this combined Report. _____

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Part B. Personal Respondent Information

1. Name:_____

2. Title:_____

3. Telephone No:_____ Facsimile No: _____

Part C. Calendar Year Information for _____
(year)

1. Net earned premium for all group and individual health benefits plans: $ _____

2. Number of non-group persons enrolled by the Carrier:

   a. Community rated and modified community rated persons _____
   b. Community rated conversion policy persons _____
   c. Medicare cost and risk persons _____
   d. Medicaid recipients _____
   e. HealthStart Plus recipients _____

   Non-group Total _____

3. Net paid loss report for Individual Health Benefits Plans:

   a. PREMIUM EARNED
   Community rated and modified community rated $

   b. CLAIMS PAID (–)
   Community rated and modified community rated $

   c. EXPENSES (–)
   Community rated and modified community rated $

   d. SUBSIDIES (+)
   (BCBSNJ only; 1992 only)

   e. NET INVESTMENT INCOME (+)
   Community rated and modified community rated $

   f. NET PAID GAIN/(LOSS)
   Community rated and modified community rated $ _____

   g. REIMBURSEMENT SOUGHT $ _____
   (For 1992: Limited to the Lesser of $10,000,000 or 50% of the Net Paid Loss)

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provision of N.J.A.C. 11:20-8.

_____ _____ _____
Signature Title Date

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EMERGENCY ADOPTIONS

INSURANCE

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Insurance Holding Company Systems

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:1-35

Adopted Emergency Amendment and Concurrent Proposed Amendment: N.J.A.C. 11:1-32.4

Emergency New Rules and Amendment Adopted and Concurrent Proposed New Rules and Amendment Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules and Amendment Filed: August 16, 1993 as R.1993 d.445.

Authority: N.J.S.A. 17:1C-6(e), 17:1-8.1, 17:27A-1 et seq. and P.L. 1993, c.241.

Concurrent Proposal Number: PRN 1993-508.

Emergency New Rules and Amendment Effective Date: August 16, 1993.

Emergency New Rules and Amendment Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason
Assistant Commissioner
Legislative and Rgulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

These new rules and amendment were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules and amendment are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules and amendment become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The emergency adoption and concurrent proposal follows:

Summary

N.J.S.A. 17:27A-1 et seq., as amended by P.L. 1993, c.241 (effective August 9, 1993), governs the merger or acquisition of control of domestic insurers and the operations of insurance holding company systems in this State. This statute establishes procedures which enable the Commissioner of Insurance (Commissioner) to ascertain the solvency, management performance and operational results of an acquiring party so as to protect the insurer's policyholders.

N.J.S.A. 17:27A-1 et seq., as amended, requires that persons seeking to acquire control of, or merge with a domestic insurer, file a statement with the Commissioner containing specified information to enable the Commissioner to review the proposed action and determine whether it may be approved pursuant to N.J.S.A. 17:27A-2b. For example, an "acquisition statement" must contain the name of each person effecting the acquisition, the source and amount of consideration, and audited financial information.

The statute also requires insurers which are members of an insurance holding company system to file a registration statement with the Commissioner on an annual basis containing specified information. For example, a registration statement must contain information regarding the identity and relationship of members of the holding company system, and specified agreements in force or transactions that occurred within the preceding calendar year between the insurer and its affiliates (such as loans, investments, management and service contracts, and dividends and other distributions to shareholders).

Finally, the statute requires that a domestic insurer notify the Commissioner at least 30 days prior to entering into specified transactions, and the insurer may not enter into such a transaction unless the Commissioner has not disapproved it within that 30-day period. Examples of transactions requiring prior notification include: sales, purchases, exchanges, or loans or extensions of credit exceeding specified amounts of the insurer's admitted assets or surplus; reinsurance agreements where the reinsurance premium equals or exceeds a specified amount of the insurer's surplus; management agreements; service contracts; and cost sharing arrangements.

In order to implement this statute, the Department proposes these new rules to provide the filing formats and procedural requirements governing the filing of acquisition statements and registration and notification requirements for insurers which are members of an insurance holding company system. These rules are based on a model regulation adopted by the National Association of Insurance Commissioners (NAIC).

These rules will provide a uniform filing format for information required to be filed by insurers and other persons subject to N.J.S.A. 17:27A-1 et seq. This, in turn, will ensure that these entities will be fully apprised of the filing requirements pursuant to that statute, thus streamlining the filing and review process of such required information, and helping to ensure consistency in the review of data submitted. The Department also notes that adoption of these rules is required to satisfy the minimum financial regulatory standards established by the NAIC to become an "accredited state."

Finally, this proposal amends N.J.A.C. 11:1-32.4 to establish fees to help defray costs of Department review of ordinary and extraordinary dividends pursuant to P.L. 1993, c.241, section 10. The fees proposed to be established are $500.00 for review of ordinary dividends, and $1,000 for review of extraordinary dividends. The Department believes that these fees are reasonable, appropriate and consistent with the average costs to the Department in reviewing these submissions, particularly in light of the additional duties imposed on the Department by N.J.S.A. 17:27A-4 as amended with respect to the review of dividends. These fees are in addition to the fees currently charged for review of acquisition statements and hearings associated with proposed acquisitions set forth at N.J.A.C. 11:1-32.4(a)4 and 5.

Proposed N.J.A.C. 11:1-35.1 sets forth the purpose and scope of the proposed new rules.

Proposed N.J.A.C. 11:1-35.2 sets forth the definition of terms used throughout the subchapter.

Proposed N.J.A.C. 11:1-35.3 sets forth general requirements governing the submission of statements required to be filed pursuant to N.J.S.A. 17:27A-2, 17:27A-3 and 17:27A-4.

Proposed N.J.A.C. 11:1-35.4 sets forth specific procedures governing the submission of information by incorporation by reference, as well as providing procedures governing summaries of required information and omitted information.

Proposed N.J.A.C. 11:1-35.5 sets forth procedures governing submission of additional information and exhibits.

Proposed N.J.A.C. 11:1-35.6 sets forth procedures specifically governing the filing of acquisition statements required pursuant to N.J.S.A. 17:27A-2.

Proposed N.J.A.C. 11:1-35.7 sets forth procedures specifically governing the filing of an annual registration statement required to be filed pursuant to N.J.S.A. 17:27A-3.

Proposed N.J.A.C. 11:1-35.8 provides for alternative and consolidated filings of registration statements on behalf of affiliated insurers.

Proposed N.J.A.C. 11:1-35.9 sets forth procedures for disclaimer of affiliation or requests for termination of registration.

Proposed N.J.A.C. 11:1-35.10 sets forth procedures governing notification of proposed transactions required to be filed pursuant to N.J.S.A. 17:27A-4.

Proposed N.J.A.C. 11:1-35.11 sets forth procedures governing determinations of the adequacy of an insurer's surplus by the Commissioner pursuant to N.J.S.A. 17:27A-4b.

Proposed N.J.A.C. 11:1-35.12 sets forth the penalties for violations of this subchapter.

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Social Impact

These proposed new rules and amendment will strengthen the Department's regulatory framework by which it governs mergers and acquisitions of control of domestic insurers, and its oversight of insurers which are members of an insurance company holding system to ascertain the solvency, management, performance and operational results of the acquiring party or holding company to protect the insurer's policyholders consistent with N.J.S.A. 17:27A-1 et seq.

The Department believes that these proposed rules will similarly benefit insurers by providing clear, concise and uniform instructions and filing formats for the filing of information required pursuant to N.J.S.A. 17:27A-2, 17:27A-3, and 17:27A-4. This in turn should streamline the filing process and the review of information filed, and help ensure consistency and uniformity in the Department's review and analysis of the data submitted.

Economic Impact

Insurers will be required to bear the cost of filing required information in the format set forth in these rules, and will be required to pay the filing fees to cover Department costs for review of the information submitted, and to bear other costs related to acquisition hearings. Many of these fees, however, are not new, but rather reflect fees and costs previously imposed. The Department, therefore, believes that any additional costs should be minimal. These rules do not impose additional reporting requirements. Rather, the rules merely provide uniform guidelines by which insurers and other persons shall file information required by statute. The Department further believes that through the provision of uniform guidelines for the filing of required information, the likelihood that the filer will submit inaccurate or incomplete data should be reduced. This, in turn, should eliminate any costs to filers and the Department associated with the request for, and the filing and review of, additional or supplemental information.

Moreover, as noted in the proposal Summary above, these rules are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit policyholders and insurers.

The Department will be required to bear any costs associated with reviewing the information filed. As noted above, however, these rules do not independently impose additional filing requirements but merely provide a format for the filing of information currently required by N.J.S.A. 17:27A-1 et seq. Moreover, the filing fees to be established will help defray some of the costs to the Department associated with the review of the information submitted.

The Department, however, will experience an economic impact as a result of implementation of accreditation standards, which includes these proposed rules. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the imposition of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

These proposed rules may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act N.J.S.A. 52:14B-16 et seq. The proposed rules will apply to small businesses which are persons or other insurers required to file information pursuant to N.J.S.A. 17:27A-1 et seq. As noted previously, however, the proposed new rules do not impose new reporting or recordkeeping requirements, but merely establish the form by which statutorily required information is to be submitted to the Department. Insurers and other persons subject to N.J.S.A. 17:27A-1 et seq. will be required to bear any costs associated with filing the required information in the format prescribed and to pay the required existing and proposed filing fee(s). To the extent that the proposed new rules apply to small businesses, they may impose a greater impact on small businesses in that they may be required to devote proportionately more staff and financial resources to comply with these rules. However, for the reasons set forth above, the Department believes that any additional adverse impact should be minimal.

The proposed new rules provide no exemption or different compliance requirements based on insurer size. These rules merely set forth the format in which information required to be filed pursuant to N.J.S.A. 17:27A-1 et seq. is to be submitted to the Department for review. The statute does not provide any exemptions from those filing requirements based on business size. Accordingly, for the reasons set forth above, and to ensure consistency and uniformity in the data submitted, no differentiation is provided based on business size.

Full text of the emergency adoption and concurrent proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:1-32.4 Fees; general

(a) (No change.)

(b) The following fees shall be paid for services provided by the Commissioner in addition to those set forth in (a) above as follows:

1.-11. (No change.)

12. Processing an application for the issuance of a Certificate of Registration pursuant to N.J.A.C. 11:3-3—$1,000; processing an application of renewal of a Certificate of Registration—$250.00; [and]

13. Processing an application for issuance or renewal of a Certificate of Order Granting Exemption from Insuring Liability for Compensation pursuant to N.J.A.C. 11:2-33—$1,000; **and**

14.-Each submission or resubmission for review of payment of an extraordinary dividend or distribution pursuant to N.J.S.A. 17:27A-4—$1,000; each submission or resubmission for review of payment of an ordinary dividend or distribution pursuant to N.J.S.A. 17:27A-4—$500.00.

SUBCHAPTER 35. INSURANCE HOLDING COMPANY SYSTEMS

11:1-35.1 Purpose and scope

(a) The purpose of this subchapter is to set forth filing and procedural requirements governing the filing of required information with respect to the acquisition of control of, or merger with, a domestic insurer, and registration and notification requirements for insurers which are members of an insurance holding company system, pursuant to N.J.S.A. 17:27A-1 et seq.

(b) This subchapter shall apply to any person, insurer, subsidiary or insurance holding company system subject to the requirements set forth in N.J.S.A. 17:27A-1 et seq.

11:1-35.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Acquisition" means any agreement, arrangement or activity, the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes, but is not limited to, the acquisition of voting securities, and assets, and bulk reinsurance and mergers.

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

"Alien insurer" means an insurer formed under the laws of any country other than the United States, its states, districts, territories, commonwealth and possessions.

"Authorized insurer" means a foreign or alien insurer, duly authorized by a certificate of authority issued by the Commissioner to transact insurance in this State pursuant to N.J.S.A. 17:32-1 et seq. or 17B:23-1 et seq.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Control" is as defined at N.J.S.A. 17:27A-1c.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of this State.

"Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

"Foreign insurer" means an insurer formed under the laws of a jurisdiction of the United States other than this State, and shall include an alien insurer except where clearly noted otherwise.

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"Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

"Insurer" means any person or persons, corporation, partnership, or company authorized by the laws of this State to transact the business of insurance in this State, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or a political subdivision of a state.

"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

"Principal insurer" means the insurer with the largest amount of direct written premium within the holding company system as shown by the last filed annual statement.

"Subsidiary" of a specified person is an affiliate controlled by such person directly, or indirectly through one or more intermediaries.

"Ultimate controlling person" means that person which is not controlled by any other person.

"Unauthorized insurer" means an insurer that is not an authorized insurer.

"Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

11:1-35.3 Forms; general requirements

(a) All statements required to be filed pursuant to N.J.S.A. 17:27A-2, 17:27A-3 and 17:27A-4 shall be submitted in accordance with the forms set forth at Exhibits A, B, C, and D, in the Appendix incorporated herein by reference, as applicable. The forms shall be considered blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(b) Seven complete copies of each Exhibit A statement, and one copy of each Exhibit B, C and D, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery or mail addressed to:

Holding Company Submissions
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

(c) A copy of Exhibit C shall be filed in each state in which an insurer is authorized to do business, if the commissioner or other regulatory official of that state has notified the insurer of its request in writing, in which case the insurer shall file such forms within 30 days of receipt of the notice. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

(d) Statements and information required pursuant to Exhibit A shall be in loose-leaf form inserted into standard two-ring or three-ring binders. The loose-leaf sheets used shall be eight and one-half inches wide and 11 inches long and punched for two-ring and three-ring binders as appropriate. In the case of information required pursuant Exhibits A, B, C or D, exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency shall be converted into United States currency.

11:1-35.4 Forms; incorporation by reference, summaries and omissions

(a) Information required pursuant to any item set forth in Exhibits A, B or D may be incorporated by reference in an answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in the answer or partial answer to any item of Exhibits A, B or D provided such document or paper is filed as an appendix or exhibit to the appropriate Exhibit A, B or D. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

(b) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three years and may be qualified in its entirety by such reference.

11:1-35.5 Forms, additional information and exhibits

(a) In addition to the information expressly required to be included in Exhibits A, B, C and D, the person making the filing shall include such further material information, if any, as may be necessary to make the information contained therein not misleading, as well as any additional information the Commissioner may specifically request from a particular filer.

(b) The person making the filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Exhibits A, B, C and D shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change rather than the date of the original filing.

11:1-35.6 Acquisition of control; statement filing; procedures

(a) A person required to file a statement pursuant to N.J.S.A. 17:27A-2 shall furnish the required information set forth in Exhibit A.

(b) The applicant shall advise the Commissioner within two business days of any changes in the facts or information submitted pursuant to (a) above arising subsequent to the date such information was furnished.

(c) If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of N.J.S.A. 17:27A-2a, the name of the domestic insurer on the cover page shall be indicated as follows:

1. "ABC Insurance Company, a subsidiary of XYZ Holding Company."

(d) Where a domestic insurer, as defined in N.J.S.A. 17:27A-2a, is being acquired, references to "the insurer" contained in Exhibit A shall refer to both the domestic subsidiary insurer and the person being acquired.

(e) The time frames for the scheduling of the public hearing on the proposed acquisition as set forth in N.J.S.A. 17:27A-2d(2) shall not commence until all of the information required to be contained in an acquisition statement as set forth in N.J.S.A. 17:27A-2 and this subchapter has been received by the Commissioner.

(f) Upon the scheduling of the hearing, the acquiring party shall cause notice of the hearing to be published in not less than two newspapers of general circulation in this State. Such notice shall include, but not be limited to, the name of the acquiring party, the name of the insurer proposed to be acquired, and the time and place for the hearing. Such notice shall be published not later than seven days, nor earlier than 14 days, prior to the scheduled date of the hearing.

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(g) A verbatim transcript of a hearing held pursuant to N.J.S.A. 17:27A-2d shall be made, and the costs thereof shall be borne by the acquiring party.

(h) Until the day of the hearing, any information received pursuant to N.J.S.A. 17:27A-2b or this subchapter as part of an acquisition of control statement filing shall be confidential and shall not be subject to public inspection or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq.

11:1-35.7 Annual registration of insurers

(a) An insurer required to file an annual registration statement pursuant to N.J.S.A. 17:27A-3 shall furnish the information set forth in Exhibit B within the time frames set forth in N.J.S.A. 17:27A-3a.

(b) An insurer required to file an annual registration statement pursuant to N.J.S.A. 17:27A-3 also shall furnish information set forth on Exhibit C. The insurer shall file a copy of Exhibit C in each state in which the insurer is authorized to do business, if requested by the Commissioner or other regulatory official of that state.

(c) The insurer shall file an amendment to Exhibit B within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement. Amendments shall be filed in the format of Exhibit B. Only items which are being amended shall be reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert year)" and shall indicate the date of the change rather than the date of the original filing.

11:1-35.8 Alternative and consolidated registrations

(a) Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register pursuant to N.J.S.A. 17:27A-3. The registration statement may include information not required by N.J.S.A. 17:27A-1 et seq. regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this State. In lieu of filing a registration statement in the format of Exhibit B, the authorized insurer may file a copy of the registration or similar report which it is required to file in its state of domicile, provided that:

1. The statement or report contains substantially similar information required to be furnished on Exhibit B; and

2. The filing insurer is the principal insurer in the insurance holding company system.

(b) An insurer filing a registration statement or report in lieu of Exhibit B on behalf of an affiliated insurer shall provide a brief statement of facts to substantiate the filing insurer's claims that it, in fact, is the principal insurer in the insurance holding company system.

(c) With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under paragraph (a) above.

(d) Except as provided at (c) above, any insurer may make consolidated or alternate filings as set forth in this section without the prior approval of the Commissioner. The Commissioner, however, may require individual filings at any time if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.

11:1-35.9 Disclaimers and termination of registration

(a) A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

1. The number of authorized, issued and outstanding voting securities of the subject;

2. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

3. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person; and

4. A statement explaining why such person should not be considered to control the subject.

(b) A request for termination of registration shall be deemed to have been granted unless the Commissioner, within 30 days after receipt of the request, notifies the registrant otherwise.

11:1-35.10 Transactions subject to prior notice

(a) An insurer required to give notice of a proposed transaction pursuant to N.J.S.A. 17:27A-4 shall furnish the required information as set forth in Exhibit D within the applicable time frames set forth in N.J.S.A. 17:27A-4.

(b) Notification of extraordinary dividends and any other ordinary dividend distribution to shareholders shall include the following information:

1. The amount of the proposed dividend;

2. The date established for payment of the dividend;

3. A statement as to whether the dividend is to be in cash or other property. If the dividend is in property, a description thereof shall be provided, as well as a description of its cost, fair market value, and an explanation of the basis for valuation;

4. A copy of the work paper calculations determining whether the proposed dividend is an extraordinary dividend as defined in N.J.S.A. 17:27A-4c(2)(b). The work paper shall include the following information:

i. The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

ii. The insurer's surplus as regards policyholders (total capital and surplus) as of the 31st of December next preceding;

iii. If the insurer is a life insurer, the net gain from operations less realized capital gains for the 12-month period ending the 31st day of December next preceding; and

iv. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding;

5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted;

6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs; and

7. The non-refundable filing fee as set forth at N.J.A.C. 11:1-32.4(b)14.

11:1-35.11 Adequacy of surplus

In determining the adequacy and reasonableness of an insurer's surplus, the Commissioner shall consider the factors set forth in N.J.S.A. 17:27A-4b, among others, and need not consider any single factor as necessarily controlling. The Commissioner may consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner shall consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner shall consider the individual subsidiary and may discount or disallow its valuation to the extent that, in his or her judgment, the individual investment so warrants.

11:1-35.12 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

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APPENDIX

EXHIBIT A

Form A
STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____
Name of Domestic Insurer

BY

_____
Name of Acquiring Person (Applicant)

filed with the Insurance Department of the State of

NEW JERSEY

Dated:_____, 19____

Name, title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____

_____

_____

_____

ITEM 1. INSURER AND METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant, regardless of the amount of the affiliate's total assets. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (for example, corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

State the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10 percent or more of the voting securities of the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupation, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business, corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other consideration used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was determined. A copy of the final executed purchase agreement shall also be attached to this statement, unless the insurer being acquired is in rehabilitation. In such a case, a copy of the draft purchase agreement shall nevertheless be attached, which shall reflect the general terms for the purchase as agreed to by the parties as of the date of the filing.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchase of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

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ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) (including trusts, partnerships or corporations) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the Commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. In the case of annual statements for individuals, in lieu of an annual statement certified by an independent certified public accountant, the Commissioner may accept annual statements for individuals that conform with the Institute of Certified Public Accountants Guidelines for Financial Compilation, or such similar guidelines acceptable to the Commissioner. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or N.J.A.C. 11:1-35.3.

ITEM 13. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-2 _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19____

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19____, for and on behalf of _____; that (s)he is the _____ of
(Name of Applicant) (Title of Officer)
such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

EXHIBIT B

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of

NEW JERSEY

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____ , 19____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____

_____

_____

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ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance company system; and the method(s) by which control of each Registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system, regardless of the amount of the affiliate's total assets. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (for example, corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system, furnish the following information:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure of the person, that is, corporation, partnership, individual, trust, etc.

(e) The principal business of the person.

(f) The name and address of any person who holds or owns 10 percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(2) Purchases, sales or exchanges of assets;

(3) Transactions not in the ordinary course of business;

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) All management agreements, service contracts and all cost-sharing arrangements;

(6) Reinsurance agreements;

(7) Dividends and other distributions to shareholders, including the declarations and authorizations thereof;

(8) Consolidated tax allocation agreements; and

(9) Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material.

Sales, purchases, exchanges, loans or extensions of credit, investments, guarantees or other contingent obligations involving 0.5 percent or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceedings is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate controlling person including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the Commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person, and any additional documents or papers required by Form B or N.J.A.C. 11:1-35.3.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

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SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-3, the Registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19_____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 19 ____, for and on behalf of _____; that (s)he is the
(Name of Company)

_____ of such company and that (s)he is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

EXHIBIT C

FORM C

SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of NEW JERSEY

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____ , 19____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____ _____

_____

_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific reference to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership of holdings of 10 percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-3, the Registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19_____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached summary of registration statement dated _____, 19____, for and on behalf of _____; that (s)he is the
(Name of Company)

_____ of such company and that (s)he is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

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EXHIBIT D

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of NEW JERSEY

By

_____

Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____ , 19____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____

_____

_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, that is, corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given pursuant to N.J.S.A. 17:27A-4a(2)(a), a(2)(b), a(2)(c), a(2)(d) or a(2)(e).

(b) A statement of the nature of the transaction.

(c) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR OTHER CONTINGENT OBLIGATIONS, INVESTMENTS OR LOANS COLLATERALIZED BY THE STOCK OF A SUBSIDIARY OR AFFILIATE

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee or other contingent obligation, investment, or loan collateralized by the stock of a subsidiary or affiliate; whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice; a description of the terms of any securities being received, if any; and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders or, (b) in the case of life insurers, 3 percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of, or make investments in, any affiliate. Describe the amount and source of duns, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders or, with respect to life insurers, 3 percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described in N.J.S.A. 17:27A-4a(2)(c), furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5 percent of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed.

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement.

(b) A description of the period of time during which the agreement is to be in effect.

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(c) A brief description of each party's expenses or costs covered by the agreement.

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-4,

_____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19____.

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, 19____, for and on behalf of _____; that (s)he is the _____ of such
(Name of Company) (Title of Officer)

company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Examination of Insurers

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:1-36

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993, d.446.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), and P.L.1993, c.236.

Concurrent Proposal Number: PRN 1993-509.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625-0325

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The emergency adoption and concurrent proposal follows:

Summary

P.L.1993, c.236 (effective August 9, 1993) provides for a revised scheme under which the Department of Insurance ("Department") conducts examinations of insurers transacting business in this State. This statute is based on a model law from the National Association of Insurance Commissioners (NAIC). The statute continues to provide the Commissioner of Insurance ("Commissioner") with the flexibility provided under prior law to examine insurers whenever he deems it appropriate. The current statute expands the Commissioner's authority to examine any other person if the Commissioner believes such examination is necessary to the examination of the insurers; and to issue subpoenas and to administer oaths to persons in connection with an examination.

An examination may take the form of a comprehensive review of all of an insurer's business affairs and its financial condition (hereinafter referred to as a "comprehensive examination" or "financial condition examination"), or may be more limited to an examination of an insurer's business practices in this State for a particular line or lines of business, such as a market conduct examination. The Department proposes these new rules to provide and clarify procedures and processes involved in an examination to implement specific provisions of P.L.1993, c.236 as discussed below.

Section 5 of the statute provides specific time frames for the adoption of examination reports and for insurance companies to provide any written submission or rebuttal with respect to matters contained in an examination report following the completion of the examination. The statute does not, however, define when an examination is "complete." The Department therefore proposes these new rules to provide uniform standards and procedures by which an examination may be deemed "complete." Examination of an insurer consists of both review and analysis of information and documentation related to the examination in addition to the gathering of information "on site" by the examiner or examiners. Accordingly, sufficient time must be provided to ensure that all required information and documentation has been provided, and to permit an adequate review and analysis thereof, before an examination is deemed complete. Therefore, these proposed new rules provide that an examination shall be deemed complete not later than 90 days after the examiner leaves the site of the insurer being examined or 90 days after the insurer responds to the last written request from the Department to provide additional information or documentation. The rules also provide that for good cause the Chief Insurance Examiner of the Department may extend these time frames for a period of time not to exceed 90 days. In the case of "joint examinations" of member insurers of an insurance holding company system, however, the "lead state" (the state where the parent company is domiciled or where the largest subsidiary is domiciled) is in control of the examination process. Where this State is not the lead state, procedures and time frames of other states involved may not be established or may be different. Accordingly, the proposed rules provide that in the case of a joint examination where the lead state is other than this State, the time frames established by these rules do not directly apply, but may nevertheless apply with the agreement of the lead state.

The Department also notes that this proposed rule governing determination of when an examination is "complete" applies only in the case of a comprehensive examination of the insurer. The Department interprets the provisions of section 5 of the statute governing the process and procedures for the adoption of examination reports to apply only to reports which contain findings resulting from a comprehensive examination of the insurer. The Department believes that such an interpretation is appropriate in that comprehensive examinations are broad in scope and are expected to be relied upon by other jurisdictions. Other examinations, such as market conduct examinations, are more limited in scope, are usually conducted in response to a known or perceived problem and generally address only an insurer's business in this State for a particular line or lines of business. Application of the procedures

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only to comprehensive or financial condition examinations is consistent with the NAIC model examination law and NAIC's Financial Regulation and Accreditation Program, which focuses on the surveillance of insurer's financial condition. However, to the extent a market conduct examination is included within the scope of a comprehensive examination, the filing procedures set forth in the statute and the deemer procedures set forth in these rules would apply.

Further, section 3 of the statute requires that the Commissioner conduct an examination of every insurer licensed in this State not less frequently than once every five years, consistent with prior law and Department practice. However, in lieu of an examination under this statute of any foreign or alien insurer licensed in this State, the Commissioner may accept an examination report on the insurer as prepared by the insurance department or regulatory agency of the insurer's state of domicile or port-of-entry state. After January 1, 1994, however, such examinations may only be accepted if the insurance department or other regulatory agency was, at the time of the examination, accredited under the NAIC's Financial Regulations and Accreditation Program, or the examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners employed by such an accredited state insurance department. In order to implement this provision, the proposed rules require that any foreign or alien insurer licensed to transact business in this State provide a copy of the examination report of its state of domicile or port-of-entry state to this Department with appropriate certifications as to such state's accreditation status or the procedures under which the examination was performed. The Department believes that these requirements are reasonable and necessary for the Department to determine whether it may accept examinations of foreign or alien insurers conducted by the domiciliary agency under the limited circumstances set forth in the statute. These provisions, however, apply only to comprehensive examinations of insurers for the reasons discussed previously.

Finally, sections 3d and 4d of the statute provide that the expenses of the examination, proceedings under the statute or retention of attorneys, appraisers, independent actuaries or other professionals or specialists shall be borne by the insurer being examined. The proposed rules implement these provisions by setting forth procedures for the billing and payment by insurers of these fees. This provision essentially codifies current Department practice, and thus should not impose any additional burden on insurers.

The Department believes that these proposed new rules thus provide clarifications of procedures and processes necessary to implement P.L.1993, c.236, and will ensure that all insurers are fully apprised of these procedures. This, in turn, should reduce confusion regarding examination procedures and help streamline the examination process, thus benefiting both insurers and the Department.

Proposed N.J.A.C. 11:1-36.1 sets forth the purpose and scope of the proposed new rules.

Proposed N.J.A.C. 11:1-36.2 sets forth the definitions of terms used throughout these rules.

Proposed N.J.A.C. 11:1-36.3 provides procedures for determining when a comprehensive or financial condition examination is deemed "complete."

Proposed N.J.A.C. 11:1-36.4 sets forth procedures for the filing of financial condition examination reports of foreign or alien insurers conducted by the domiciliary jurisdiction.

Proposed N.J.A.C. 11:1-36.5 sets forth procedures for the payment of expenses of examinations incurred by the Department pursuant to P.L.1993, c.236.

Proposed N.J.A.C. 11:1-36.6 sets forth penalties for violations of the rules.

Social Impact

These proposed new rules implement P.L.1993, c.236 and provide clarifications, procedures and processes necessary to implement specified provisions of this statute. This, in turn, will ensure that all insurers are fully apprised of the examination procedures, which should help streamline the examination process. This, in turn, should benefit insurers and the Department.

Economic Impact

These proposed new rules should not directly impose any additional costs to insurers. Rather, these rules provide procedures and processes required to implement P.L.1993, c.236 with respect to the examination of insurers. While insurers will be required to bear all expenses related to the examinations of insurers conducted by the Department, such duty is imposed by statute, not these rules. These rules merely provide the processes and procedures to implement these statutory requirements.

Regulatory Flexibility Analysis

The proposed new rules may apply to small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the new rules apply to "small businesses" they will be insurers authorized to transact insurance in this State. The Department does not believe, however, that insurers should experience any adverse economic impact directly through the proposed new rules. To the extent additional costs are imposed on small business, such costs are generally imposed by statute, not these rules. These proposed new rules merely implement existing law and provide procedures and processes by which examinations of insurers shall be conducted pursuant to the requirements set forth in P.L.1993, c.236.

Moreover, pursuant to P.L.1993, c.236, an insurer bears the costs incurred by the Department to examine that particular insurer. To the extent that an examination of an insurer writing little business in this State is less complex, costs to the insurer for the examination would be correspondingly reduced.

These proposed rules, however, do not provide any different compliance requirements based specifically on insurer size. These rules provide procedures and processes by which the Department will conduct examinations of insurers pursuant to P.L.1993, c.236. This statute does not provide any differentiation based on insurer size. For the foregoing reasons, and to ensure consistency and uniformity in the method by which insurers are examined, these rules provide no differentiation in compliance requirements based on insurer size.

Full text of the emergency adoption and concurrent proposal follows:

SUBCHAPTER 36. EXAMINATION OF INSURERS

11:1-36.1 Purpose and scope

(a) This subchapter sets forth certain procedures and processes for the examination of the financial condition of a company and for the payment of expenses of any examination conducted pursuant to P.L.1993, c.236.

(b) This subchapter applies to all insurers licensed to transact insurance in this State and to any company or person subject to examination by the Commissioner pursuant to P.L.1993, c.236.

11:1-36.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Alien insurer" means an insurer formed under the laws of any country other than the United States, its states, districts, territories, commonwealths and possessions.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Company" means any insurer or other person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the Commissioner.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of this State.

"Examiner" means any individual or firm authorized by the Commissioner to conduct an examination pursuant to P.L.1993, c.236.

"Financial condition examination" means a comprehensive examination of the assets and liabilities, method of conducting business and all other affairs of any company which is the subject matter of the examination report filed pursuant to the procedures set forth in P.L.1993, c.236 and this subchapter.

"Foreign insurer" means an insurer formed under the laws of a jurisdiction of the United States other than this State.

"Insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer or other person engaged in the business of insurance pursuant to Subtitle 3 of the Title 17 of the Revised Statutes or Subtitle 3 of the Title 17B of the New Jersey Statutes.

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"Joint examination" means the examination of affiliated insurers that have any type of interinsurance, reinsurance, or other business dealings, and of insurers that have, through reinsurance affiliations, provided 35 percent or more of the existing surplus support at the as-of-date of the examination.

"Lead state" means the state where the parent insurer is domiciled or, if there is no insurer parent, the state where the largest (by direct written premium volume as shown by the last filed annual statement) insurer subsidiary is domiciled.

"NAIC" means the National Association of Insurance Commissioners.

11:1-36.3 Examination; when deemed complete

(a) For purposes of P.L.1993, c.236, section 5b, an examination of the financial condition of a company shall be deemed complete not later than 90 days after the date the examiner leaves the site of the company, or not later than 90 days after the date the company responds to the last written request from the examiner(s) for additional information, but in no event later than 180 days after the date the examiner leaves the site of the company provided that the company has responded to any written request for additional information made 90 days or more prior to that date. For good cause, the Chief Insurance Examiner of the Department may extend these time frames for an additional period of time not to exceed 90 days.

(b) A company shall provide any additional information, documentation or other data requested by an examiner not later than 30 days after such request.

(c) In the case of joint examinations, the time frames set forth in (a) above shall apply where this State is the lead state conducting such joint examination. Where this State is not the lead state, the time frames set forth in (a) above may apply with the agreement of the lead State.

11:1-36.4 Foreign and alien insurers; filing of examination reports with this State

(a) A foreign or alien insurer licensed to transact business in this State shall file with the Department a copy of the financial condition examination report prepared by the insurance department or other regulatory agency for the insurer's state of domicile or port-of-entry state.

1. The copy of the examination report shall be filed not later than 180 days after the report is adopted by the insurance department or regulatory agency of the insurer's state of domicile or port-of-entry state, and shall be certified by such department or agency as representing a true and accurate report of the examination conducted by its duly appointed examiner in charge who satisfies the minimum qualifications to be the examiner in charge of such examination as set forth in the Examiners' Handbook adopted by the NAIC as in effect at the time such examination was conducted.

2. After January 1, 1994, in addition to the requirements set forth in (a) and (a)1 above, the insurer shall provide a certification from the insurance department or regulatory agency that:

i. The insurance department or regulatory agency was at the time of the examination accredited under the NAIC's Financial Regulation Standards and Accreditation Program; or

ii. The examination was performed under the supervision of an accredited insurance department or other regulatory agency or with the participation of one or more examiners who are employed by such an accredited state insurance department or other regulatory agency who satisfy the minimum qualifications to be an examiner as set forth in the Examiners' Handbook adopted by the NAIC as in effect at the time the examination was conducted and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department or other regulatory agency.

11:1-36.5 Payment of expenses

(a) Pursuant to P.L.1993, c.236, section 3d, the reasonable expenses of any examination and proceedings conducted under that statute shall be fixed and determined by the Commissioner, and he or she shall collect them from the company examined, which shall pay them on a presentation of an account of expenses. Any and all such receipts shall be appropriated to the Department for use in defraying the expenses of such examination. If any company, after examination, is adjudged insolvent by a court of competent jurisdiction, the expense of the examination, if unpaid, shall be ordered out of the assets of the company.

(b) Pursuant to P.L.1993, c.236, section 4d, the Commissioner may, in making an examination under that statute, retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals as examiners, the cost of which shall be borne by the company being examined. Upon presentation of a detailed invoice for such fees and expenses, and upon review and approval by the Commissioner of the adequacy and reasonableness of such fees and expenses, the Commissioner shall authorize and direct that the company pay such amount directly to the third party retained by the Commissioner to assist in the examination. The company shall make such payment within 30 days of the Commissioner's approval of the adequacy and reasonableness of such fees and expenses.

11:1-36.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Determination of Insurers in a Hazardous Financial Condition

Adopted Emergency New Rule and Amendments and Concurrent Proposed New Rule and Amendments: N.J.A.C. 11:2-27

Emergency New Rule and Amendments Adopted and Concurrent Proposed New Rules and Amendments Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rule and Amendments Filed: August 16, 1993 as R.1993 d.447.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:23-1 et seq., 17B:21-1 et seq., 17:27A-1 et seq., 17:30C-1 et seq., 17B:32-31 et seq., P.L. 1993, c.234, P.L. 1993, c.235, and P.L. 1993, c.245.

Concurrent Proposal Number: PRN 1993-510.

Emergency New Rule and Amendments Effective Date: August 16, 1993.

Emergency New Rule and Amendments Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
Department of Insurance
CN 325
Trenton, New Jersey 08625

These amendments and new rule were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency amendments and new rule are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted amendments and new rule become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The emergency adoption and concurrent proposal follows:

Summary

The Department of Insurance (Department) is proposing a new rule and amendments to N.J.A.C. 11:2-27. That subchapter, effective July 6,

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1992, sets forth factors which the Commissioner of Insurance (Commissioner) shall consider in determining whether an insurer is in a hazardous financial condition. A determination of hazardous financial condition provides one of the grounds upon which the Commissioner: (1) may seek an order from the Superior Court to rehabilitate, liquidate the business or conserve the assets within this State of domestic, foreign or alien insurers pursuant to N.J.S.A. 17:30C-1 et seq. and 17B:32-31 et seq.; (2) may subject an insurer to administrative supervision pursuant to P.L. 1993, c.245; and (3) may take action to revoke or nonrenew an insurer's authority to transact insurance in this State (see for example, N.J.S.A. 17:32-1 et seq. and 17B:23-1 et seq.) or to withdraw the eligibility of an eligible surplus lines insurer to insure surplus lines risks in this State (see N.J.S.A. 17:22-6.46). Examples of the factors set forth in N.J.A.C. 11:2-27 that the Commissioner shall consider include adverse findings reported in financial condition and market conduct examination reports; adverse findings from the National Association of Insurance Commissioners (NAIC) Insurance Regulatory Information System; and a finding that the insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems. The factors set forth in the rules are substantially based on a model rule from the NAIC.

The NAIC model rule also contains provisions that authorize the Commissioner to order an insurer found to be in a hazardous financial condition to take "corrective action" to abate or eliminate such hazardous financial condition, including, but not limited to: (1) reduce the total amount of present and potential liability by reinsurance; (2) reduce, suspend or limit the volume of business being accepted or renewed; (3) increase the insurer's capital and surplus; or (4) suspend or limit the declaration and payment of dividends to stockholders or policyholders. These provisions, however, were not incorporated as part of the original promulgation of N.J.A.C. 11:2-27. The Department now proposes a new rule, N.J.A.C. 11:2-27.4, to incorporate these provisions. The Department also notes that promulgation of this new rule is required to satisfy the minimum financial regulatory standards established by the NAIC to become an "accredited state."

The "corrective actions" that the Commissioner may order an insurer to take are consistent with P.L. 1993, c.245, governing the administrative supervision of insurers. Pursuant to that statute, if an insurer is placed under administrative supervision, the Commissioner furnishes to the insurer a list of actions to be taken to abate the conditions giving rise to the supervision, and may prohibit an insurer from doing various acts without his or her prior approval for the period of supervision. Such acts include the disposal or conveyance of any of the insurer's assets, the withdrawal of any bank accounts, the investment of any funds, and the transfer of any property. Moreover, the actions which the Commissioner may order an insurer to take pursuant to the proposed new rule is consistent with the provisions set forth in the dynamic capital and surplus acts governing property/casualty and life and health insurers (which authorize the Commissioner to order an insurer to increase its capital and surplus levels based on the volume and nature of business transacted), and the Insurance Holding Company Systems Act, N.J.S.A. 17:27A-1 et seq., which authorizes the Commissioner to review and disallow any dividends or distributions to shareholders based upon a determination whether such distribution is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

The proposed new rule also provides procedures by which insurers subject to an order as described above may request a hearing, if the insurer asserts that action to be taken or proposed to be taken by the Commissioner would not result in improving the condition of the insurer. P.L. 1993, c.245, section 6. Pursuant to the Administrative Supervision Act at P.L. 1993, c.245, section 4, all proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Department are confidential. The Department interprets the Administrative Supervision Act to require that the hearing on these limited issues be conducted within the Department, since the Act requires that such hearings generally be confidential. The Department notes, however, that an insurer's right to a contested case hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., is not precluded in that the Commissioner may open proceedings or hearings to the public if he or she deems that it is in the best interest of the public, or the insurer, its insureds or creditors. Such consideration would include an affirmative request by the insurer for a contested case hearing.

The goal of the proposed new rule is to authorize the Commissioner to order an insurer which is found to be in a hazardous financial condition to take certain steps to abate or eliminate such condition, consistent with the Administrative Supervision Act. Through such action, the likelihood that the insurer will be placed in rehabilitation or liquidation may be reduced, thereby avoiding the attendant costs and disruptions to the insurer, policyholders and the market related to such proceedings.

Indeed, one commenter to the original proposal of N.J.A.C. 11:2-27 expressed concern that the then proposed rules did not incorporate the provisions of the NAIC model which authorizes the Commissioner to order the insurer to take corrective action. The commenter specifically stated that rehabilitation or liquidation should be a measure of last resort, and that the Commissioner should have the ability to order insurers to take corrective action to avoid disruptions associated with the rehabilitation and liquidation of insurers. See 24 N.J.R. 2458. The Department believes that the proposed new rule effectuates the shared goals of both the Department and the insurance industry to avoid disruptions associated with the institution of such proceedings.

Further, the Department proposes to amend N.J.A.C. 11:2-27.3 to clarify and confirm that a factor that the Commissioner may consider in determining whether an insurer is in a hazardous financial condition is a finding that the insurer fails to maintain the minimum capital and surplus or net assets, as applicable, required by statute or as otherwise required by the Commissioner pursuant to law. See, for example, P.L. 1993, c.234 and P.L. 1993, c.235.

Finally, the Department notes that it is proposing to make other technical amendments to the rules to reflect current statutory citations and to make other clarifying changes.

Social Impact

The Department believes that the proposed new rule, by authorizing the Commissioner to order an insurer to take "corrective action" upon finding that such insurer is in a hazardous financial condition, will help reduce the likelihood that delinquency proceedings will be instituted against insurers. This, in turn, will benefit policyholders, insurers and the Department by avoiding any costs associated with the rehabilitation and liquidation of insurers, including costs to the guaranty associations which are obligated to pay claims for insolvent property/casualty, life and health and surplus lines insurers. These guaranty associations are generally funded by assessments on member insurers which are ultimately borne by policyholders or the public in this State.

Economic Impact

The Department believes that no adverse economic impact should be experienced by insurers as a result of the proposed new rule. As noted in the Summary and the Social Impact statements above, the proposed new rule delineates various actions that the Commissioner may order an insurer to effectuate in order to correct a hazardous financial condition. While an insurer subject to an order issued pursuant to the proposed new rule will be required to bear any costs associated with such compliance, the Department believes that any potential burden should be minimal compared to the potential costs to the insurer, its policyholders and market generally that may be avoided. Accordingly, any costs that may be incurred are outweighed by the benefits to be achieved. Finally, the proposed amendments make only clarifying changes to the rules and these do not impose any new costs on insurers.

Moreover, as noted in the proposal Summary above, these amendments are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed amendments. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the imposition of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

The proposed new rule and amendments may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the new rule applies to "small businesses," they will be insurers authorized or eligible to transact insurance in this State. The Department does not believe that insurers

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should experience any adverse economic impact through the proposed new rule. The proposed new rule authorizes the Commissioner to order an insurer found to be in a hazardous financial condition to take "corrective action" to eliminate such existing condition. Insurers which are small businesses will be required to incur any costs of complying with an order issued by the Commissioner pursuant to the proposed new rule. The Department believes, however, that any such costs should be minimal. In fact, the Department believes that the proposed new rule should benefit insurers in that by requiring corrective action to be taken, further deterioration in an insurer's financial condition may be avoided. This, in turn, will reduce the likelihood that the insurer would be placed in rehabilitation or liquidation, thus avoiding costs to the insurer, policyholders and the market generally associated with such proceedings. The proposed amendments make clarifying changes to the rules and impose no new reporting, recordkeeping or other compliance requirements on insurers.

The proposed new rule nd amendments provide no differentiation based on insurer size. The rules merely delineate the various actions the Commissioner may order an insurer found to be in a hazardous financial condition to take in order to correct such condition, consistent with the P.L. 1993, c.245. This statute, as well as the present N.J.A.C. 11:2-27 regarding determination of hazardous financial condition, provide no differentiation based on insurer size. For this reason, and in order to ensure consistency and uniformity in the treatment of insurers found to be in a hazardous financial condition, no differentiation in compliance requirements is proposed based on insurer size.

Full text of the emergency adopted and concurrently proposed new rule and amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 27. DETERMINATION OF INSURERS IN A HAZARDOUS FINANCIAL CONDITION

11:2-27.1 Purpose **and scope**

(a) The purpose of this subchapter is to set forth the factors which the Commissioner shall consider in determining whether an insurer is in a hazardous financial condition as defined herein. A determination of hazardous financial condition provides **one of** the grounds upon which the Commissioner may seek an order from the Superior Court to rehabilitate, liquidate the business or conserve the assets within this State of domestic, foreign or alien insurers pursuant to N.J.S.A. 17:30C-1 et seq. and [17B:32-1 et seq.] **17B:32-31 et seq., or upon which an insurer may become subject to administrative supervision pursuant to P.L. 1993, c.245,** and provides one of the grounds upon which the Commissioner [shall] **may take action to revoke or nonrenew an insurer's authority to transact insurance in this State, or** withdraw the eligibility of an eligible surplus lines insurer to insure surplus lines risks in the State pursuant to **law, including, but not limited to,** N.J.S.A. **17:32-2, 17B:23-2, and** 17:22-6.46.

[11:2-27.2 Scope]

(b) This subchapter shall apply to all domestic, foreign and alien insurers and all other entities subject to N.J.S.A. 17:30C-1 et seq., [and 17B:32-1 et seq.] **17B:32-31 et seq., or P.L. 1933, c.245;** and to all eligible surplus lines insurers.

11:2-[27.3]27.2 Definitions

The following words and terms, when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

"AVR" means the asset valuation reserve calculated for purposes of completing the NAIC annual statement in accordance with its instructions and Accounting Practices and Procedures Manual.

. . .

"Insurer" means a person subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the Commissioner pursuant to N.J.S.A. 17:30C-1 et seq. [or], [17B:32-1 et seq.] **17B:32-31 et seq. or P.L. 1993, c.245,** or by the equivalent insurance supervisory official of another state. "Insurer" includes all persons purporting to be engaged in the business of insurance as an insurer in this State and all persons in the process of organization to become insurers.

. . .

["MSVR" means the mandatory securities valuation reserve as described in N.J.S.A. 17B:20-2.]

. . .

11:2-[27.4]**27.3** Determination of hazardous financial condition; factors

(a) The Commissioner shall consider the following factors, either singly or in a combination of two or more, in determining whether an insurer is in a hazardous financial condition:

1.-16. (No change.)

17. A finding that a life insurer's surplus as regards policyholders plus [MSVR] **AVR** reserves is not adequate in relation to the amount of liabilities less [MSVR] **AVR** reserves less separate account liabilities;

18. A finding that the insurer does not possess the minimum capital and surplus (in the case of stock insurers) or net assets (in the case of mutual insurers) required by statute to be maintained or as otherwise required by the Commissioner pursuant to law;

Recodify existing 18. through 28. as **19. through 29.** (No change in text.)

(b) (No change.)

11:2-27.4 Determination of hazardous financial condition; corrective action

(a) If the Commissioner determines that the continued operation of an insurer may be hazardous to the policyholders or public in this State, the Commissioner may, upon such a determination, subject the insurer to administrative supervision pursuant to P.L. 1993, c.245 and may issue an order requiring the insurer to take such actions as the Commissioner deems necessary to abate such determination, including, but not limited to:

1. Reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. Reduce, suspend or limit the volume of business being accepted or renewed;

3. Reduce general insurance and commission expenses by specified methods;

4. Increase the insurer's capital and surplus;

5. Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

6. File reports in a form acceptable to the Commissioner concerning the market value of an insurer's assets;

7. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Commissioner deems necessary;

8. Document the adequacy of premium rates in relation to the risks insured;

9. File, in addition to regular annual statements, interim financial reports on the form adopted by the NAIC or in such format as prescribed by the Commissioner; or

10. Take such other actions as the Commissioner may deem necessary in a particular case to protect the insurer's policyholders and the public.

(b) If an insurer is subject to an order issued by the Commissioner pursuant to (a) above, and the insurer objects to the actions ordered to be taken as set forth therein, the insurer may request a hearing before the Department on the Commissioner's determination within 10 days from the date of receipt of such order as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the manner wherein the action(s) ordered by the Commissioner would not result in improving the condition of the insurer.

2. Pursuant to P.L. 1993, c.245, all proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the supervision of the insurer are confidential, except as otherwise

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provided by P.L. 1993, c.245. Any confidential proceedings in connection with an order issued pursuant to this rule and P.L. 1993, c.245 shall be held by the Commissioner or his designee at the Department.

3. If the Commissioner opens such proceedings or hearings to the public pursuant to P.L. 1993, c.245, he may transmit the matter to the Office of Administrative Law for further proceedings in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(c) Nothing contained in this section shall be construed to limit or preclude the Commissioner from independently requiring an insurer to take specific actions or limit specified activities pursuant to other provisions of Title 17 or 17B of the Revised Statutes.

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Credit for Reinsurance

Adopted Emergency Rules and Concurrent Proposed New Rules: N.J.A.C. 11:2-28

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.448.

Authority: N.J.S.A. 17:1C-6(e) and P.L. 1993 c.243 (enacted August 9, 1993).

Concurrent Proposal Number: PRN 1993-511.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:

Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The New Jersey Department of Insurance ("Department") emergency adopts and concurrently proposes these new rules setting forth standards for credit for reinsurance. Adopted emergency rules become effective upon filing by the Office of Administrative Law ("OAL") (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently these new rules are being proposed for adoption in compliance with normal rulemaking requirements of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq. Adopted concurrent proposed rules become effective upon filing by the OAL if filed prior to the emergency expiration date (see N.J.A.C. 1:30-4.4(d)). The emergency adoption and concurrent proposal follow.

The National Association of Insurance Commissioners (the "NAIC") has developed a series of minimum financial regulatory standards to facilitate the financial regulation of insurers. This shall be accomplished through the development of a nationwide uniform regulatory framework. This new subchapter, based in large part on the NAIC model rules, is only one in the series of mandatory regulations which must be implemented in order for this State to obtain accreditation from the NAIC.

These proposed new rules implement the provisions of P.L. 1993, c.243 which specify the conditions under which either a domestic insurer, an insurer licensed to transact business in this State or an eligible surplus lines insurer may take a credit for reinsurance. The credit may be taken by a ceding insurer as either an asset or as a deduction from liability on the insurer's annual statement.

A ceding insurer will only be permitted to take a credit for reinsurance when the assuming insurer is either: 1) licensed to transact insurance in this State; 2) accredited as a reinsurer in this State; 3) domiciled and licensed in a state which employs standards for reinsurance similar to the standards set forth at P.L. 1993, c.243 and in these rules; or 4) maintains a trust fund in the United States for the benefit of the ceding insurer and its policyholders, to secure payment of claims. Where an assuming insurer does not meet any of the requirements set forth above, a credit may, nevertheless, be permitted in accordance with these rules.

A life and health ceding insurer which is governed by these rules shall only be permitted to take a credit for reinsurance where the reinsurance is ceded to a reinsurer which conforms to the requirements of one of the sections of this subchapter and where the reinsurance contract conforms to the provisions set forth in administrative rules regarding Reinsurance Agreements for Life, Health and Annuity Insurers at N.J.A.C. 11:2-40, emergency adopted and concurrently proposed elsewhere in this issue of the New Jersey Register.

The primary purpose of these new rules is to recognize that there are reinsurers which are not authorized to transact business in New Jersey but which are, nevertheless, financially sound. These reinsurers are secure entities from which reinsurance may be obtained and these rules, therefore, allow insurers to take a credit for insurance ceded to such reinsurers.

N.J.A.C. 11:2-28.1 sets forth the purpose and scope of these rules.

N.J.A.C. 11:2-28.2 defines the relevant terms which are used in this subchapter.

N.J.A.C. 11:2-28.3 codifies the current Department practice of permitting insurers to report and take credits for reinsurance for insurance ceded to reinsurers authorized to transact business in New Jersey.

N.J.A.C. 11:2-28.4 permits an insurer to report a credit for insurance ceded to an accredited reinsurer. That section also sets forth the criteria and procedures for a reinsurer to become accredited in this State.

N.J.A.C. 11:2-28.5 also permits credits for reinsurance ceded to foreign and alien reinsurers which are domiciled and licensed in another state or jurisdiction which employ substantially similar standards as those set forth in these new rules.

N.J.A.C. 11:2-28.6 provides that a credit for reinsurance may be obtained for insurance ceded to reinsurers which establish and maintain trust funds in the United States, in amounts sufficient to guaranty claims of policyholders. The trusts must be established in qualified United States financial institutions, according to the procedures set forth in N.J.A.C. 11:2-28.8 and 28.9. A qualified United States financial institution is defined in the definition section at N.J.A.C. 11:2-28.2.

N.J.A.C. 11:2-28.7 permits a credit for reinsurance for reinsurance ceded by operation of law.

N.J.A.C. 11:2-28.8 sets forth the manner in which a reduction from liability may be taken by a ceding insurer.

N.J.A.C. 11:2-28.9 establishes the requirements for acceptable trust agreements.

N.J.A.C. 11:2-28.10 establishes the requirements for acceptable letters of credit.

N.J.A.C. 11:2-28.11 permits a ceding insurer to take a credit for unencumbered funds withheld by the ceding insurer in the United States in connection with the reinsurance contract under which those funds are withheld, subject to withdrawal solely by, and under the exclusive control of, the ceding insurer.

N.J.A.C. 11:2-28.12 sets forth the minimum requirements for reinsurance contracts.

N.J.A.C. 11:2-28.13 establishes a compliance deadline in order to carry out the statutory requirement set forth at P.L. 1993, c.243, section 6 which states that the "act shall take effect immediately and apply to all cessions after the effective date of this act under reinsurance agreements with an inception, anniversary or renewal date on or after the 180th day following the effective date of this act."

These new rules also establish forms to be filed with the Department and the procedures and standards to be employed in evaluating whether a reinsurer is acceptable for purposes of assuming insurance from a primary insurer. An appendix has also been incorporated which includes a copy of form AR-1 which must be filed in connection with these rules.

Social Impact

These proposed rules will effectively expand the number of reinsurers from which domestic ceding insurers may take a credit for reinsurance ceded. The rules also ensure that reinsurance ceded is placed with reinsurers which are financially sound.

The rules benefit domestic insurers and the Department and also protect the interests of policyholders. The rules provide insurers with clear, concise and uniform instructions for taking credits for reinsurance ceded to appropriate reinsurers. The proposed rules will enable ceding

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insurers to increase their writings within this State while also requiring them to maintain a stable and reliable surplus in relation to such writings. The ability to write more premium benefits and direct market for insurance and the stability and reliability of surplus protects the interests of New Jersey policyholders.

These rules will also benefit the Department by streamlining procedures and facilitating the review of information submitted to the Department. These new procedures will help ensure uniformity in the Department's analysis of data submitted by insurers.

Economic Impact

The implementation of the mandatory NAIC nationwide regulatory framework will facilitate the financial regulation of insurers. By obtaining accreditation from the NAIC, New Jersey domestic insurers may avoid the additional costs that would be involved if multiple financial examinations were required by other jurisdictions. This, in turn, should benefit both policyholders and insurers.

Insurers will be required to bear the cost of filing the information required by these proposed rules. The Department believes that any additional information required by these new rules will be offset by the benefit to ceding insurers by expanding the number of reinsurers to which insurance may be ceded and by increasing insurers' ability to increase their writings and stabilize insurers' surplus.

The Department will experience an economic impact in bearing the costs associated with reviewing the information required by these rules. The Department anticipates that compliance with, and the implementation of, the NAIC accreditation standards, will require additional staffing and will generate additional costs associated therewith. Some of the costs associated with the implementation of these rules will be defrayed by the filing fees required by this subchapter.

Regulatory Flexibility Analysis

These proposed rules may apply to "small businesses" as that term is defined in the New Jersey Regulatory Flexibility Act at N.J.S.A. 52:14B-17. In accordance with this Act, only domestic insurers may be considered "small businesses." The rules apply uniformly to all insurers regardless of size and there are no exemptions or different compliance requirements based on insurer size.

The proposed rules will impose minimal new and additional recordkeeping and reporting requirements for those insurers seeking to cede insurance to reinsurers which are not licensed in New Jersey. Insurers will be required to bear the costs of such additional requirements. To the extent that these rules apply to small businesses, they may impose a greater impact on those businesses in that a proportionately larger staff and greater financial resources may be devoted to the implementation of these rules by a small insurer than by a larger insurer.

Any additional financial impact on domestic insurers, which may result from the implementation of these rules, is expected to be minimal because this subchapter merely codifies domestic insurers' existing practices. Additional expenses, if any, will be offset by the benefits to insurers.

The majority of the new reporting requirements and all recordkeeping requirements, fees and expenses relating thereto apply to reinsurers other than "domestic" insurers or reinsurers. The New Jersey Regulatory Flexibility Act does not apply to such entities.

Full text of the emergency adopted and concurrently proposed new rules follows:

SUBCHAPTER 28. CREDIT FOR REINSURANCE

11:2-28.1 Purpose and scope

(a) The purpose of these rules is to implement the provisions of P.L. 1993, c.243 by establishing procedures to be employed by insurers which cede risks to appropriate reinsurers and which assume the risk from the ceding insurers to whom these rules apply.

(b) This subchapter applies to all insurers which transact business in this State, including insurers which are domiciled in this State. This subchapter also applies to insurers which are either licensed to transact business in this State or are eligible to write surplus lines insurance in this State, and which in either case are domiciled in a state or country which does not employ standards regarding credit for reinsurance substantially similar to the standards set forth herein.

1. For a life and health ceding insurer to qualify for a credit for reinsurance in accordance with this subchapter, the ceding insurer shall also comply with the requirements of P.L. 1993, c.243 and all administrative rules promulgated thereunder concerning the regulation of life and health reinsurance contracts.

2. Where an insurer which is either licensed to transact business in this State or is an eligible surplus lines insurer in this State and in either case the state in which it is domiciled is accredited by the NAIC or employs standards regarding credit for reinsurance as determined by the Commissioner to be substantially similar to the standards set forth in these rules, the insurer shall comply with the rules regarding credit for reinsurance in its state of domicile.

11:2-28.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Annual statement" means a statement showing an insurer's financial condition at the close of business on December 31 of the preceding year and its business for that year in the form adopted by the NAIC, prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the NAIC and all applicable provisions of law.

"Assuming insurer" or "reinsurer" means any person which engages in the activity of insuring part or all of an insurance risk from an originating or ceding insurer.

"Authorized officer" means the president of the company whose signature is attested to by the secretary of the company or any such equivalent officers.

"Beneficiary" as used in connection with the establishment of a trust agreement means the entity for whose benefit the trust has been established and any successor of the beneficiary by operation of law. Where a court of competent jurisdiction appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, conservator, rehabilitator or liquidator.

"Ceding insurer" means an insurer which procures indemnification for itself from an assuming insurer with respect to all or part of an insurance risk associated with one or more policies which it issued should losses be sustained.

"Certificate of eligibility" means a certificate issued by the Commissioner evidencing the authority of an unauthorized insurer to transact the business of surplus lines insurance in this State.

"Clean and unconditional letter of credit" or "clean and unconditional confirmation" means a letter of credit or confirmation which:

1. Makes no reference to any other agreement, document or entity;

2. Provides that a beneficiary need only draw a sight draft under the letter of credit or confirmation and present it to promptly obtain funds and that no other document need be presented; and

3. Indicates that it is not subject to any conditions or qualifications outside of the letter of credit.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Date of the ceding insurer's statutory financial statement" means the period ending date for which the statutory financial statement is rendered.

"Delinquency proceeding" means, for the purpose of this subchapter, any proceeding commenced against a reinsurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such reinsurer.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of the State of New Jersey.

"Eligible surplus lines insurer" means an unauthorized insurer which is issued a certificate of eligibility to transact the business of insurance in this State and in which insurance coverage is placed or may be placed pursuant to N.J.S.A. 17:22-6.40 et seq.

"Evergreen" means a provision in a letter of credit or its confirmation which prevents the expiration of the letter of credit or its confirmation without due advance written notice to the beneficiary from the issuing or confirming bank or trust company.

"Grantor" as used in connection with the establishment of a trust agreement means the entity that has established a trust for the

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benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

"Insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq. or N.J.S.A. 17B-17-1 et seq.; any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.; any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.; any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.; or any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

"NAIC" means the National Association of Insurance Commissioners.

"Net assets" means an insurer's total admitted assets less its total reserves and other liabilities.

"Obligations" as used in connection with the establishment of a trust agreement means:

1. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;
2. Reserves for reinsured losses reported and outstanding;
3. Reserves for reinsured losses incurred but not reported; and
4. Reserves for allocated reinsured loss expenses and unearned premiums.

"Qualified United States financial institution":

1. As used at N.J.A.C. 11:2-28.8(b)3 and 28.10 means an institution that:

i. Is organized or, in the case of a branch or agency office of a foreign banking organization in the United States, licensed, under the laws of the United States or any state thereof;

ii. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and

iii. Has been determined by either the Commissioner, or the Securities Valuation Office of the NAIC, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner; or

2. As used elsewhere in this subchapter means an institution that:

i. Is organized or, in the case of a branch or agency office of a foreign banking organization in the United States, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

ii. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

"Reinsurance" means a contractual arrangement, as evidenced by a written agreement, whereby an insurer, for some consideration, agrees to indemnify a ceding insurer, for all or part of a loss which the ceding insurer may incur under one or more policies that the ceding insurer has or will issue.

"Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

"Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, which solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of that insurer unless expressly provided in a broker of record letter.

"Reinsurance intermediary-manager" means a person which has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for that reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term, except that the following persons shall not be considered a reinsurance intermediary-manager, with respect to that reinsurer, for the purposes of this subchapter:

1. An employee of the reinsurer;
2. A United States manager of a United States branch of an alien reinsurer;
3. An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to N.J.S.A. 17:27A-1 et seq., and whose compensation is not solely based on the volume of premiums written;
4. The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner or other similar regulatory officer of the state in which the manager's principal business office is located;
5. A licensed attorney-at-law who negotiates contracts or provides general financial counsel provided no commission or brokerage fee is provided.

"Substantially similar standards" means standards on credit for reinsurance which the Commissioner determines are equal to or exceed the standards of this subchapter.

"Surplus as regards policyholders" means the net assets of the insurer or assuming insurer.

11:2-28.3 Reinsurer licensed in New Jersey

An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where the assuming insurer is licensed to transact business in this State as of the date of the ceding insurer's statutory financial statement, except as limited in accordance with N.J.A.C. 11:2-27.

11:2-28.4 Reinsurer accredited in New Jersey

(a) An insurer shall be permitted to take a credit for reinsurance which it cedes to an assuming insurer where the assuming insurer is accredited as a reinsurer in this State as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which meets all of the following standards:

1. Files with the Commissioner a letter requesting approval for accreditation and listing the information upon which it will rely and is submitting in connection therewith;
2. Submits a non-refundable filing fee made payable to Treasurer, State of New Jersey, of $1,000 for an initial filing and $1,000 for a renewal filing;
3. Files with the Commissioner a properly executed form AR-1 (incorporated herein by reference as Exhibit 1 in the Appendix) which establishes that it submits to this State's jurisdiction and this State's authority to examine its books and records;
4. Files with the Commissioner a certified copy of a certificate of authority, a certificate of compliance or an equivalent document which has been properly notarized, as evidence that it is currently licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an assuming alien insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;
5. Files annually with the Commissioner:

i. A copy of its most recent annual statement filed with the insurance department of its state of domicile;

ii. Its most recent audited financial statement;

iii. A current actuarial opinion which certifies:

(1) For a property and casualty insurer, to the adequacy of the loss and loss adjustment expense reserves; or

(2) For a life and health assuming insurer that:

(A) Its policy reserves are adequate;

(B) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(C) That its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, and attaches any and all documents in support thereof; and

iv. The quarterly statement for the quarter immediately preceding the application, except for renewals which shall require the quarterly statement due May 15;

6. Maintains a surplus as regards policyholders in an amount not less than $20,000,000 and whose accreditation has not been denied by the Commissioner within 120 days of filing its submission with the Commissioner, or in the case of reinsurers with surplus as regards

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policyholders of less than $20,000,000 whose accreditation has been approved by the Commissioner; and

7. Provides any additional information which may include, but is not limited to, information which the Commissioner deems necessary to ensure that the particular reinsurer's condition and methods of operation are not such as would render its operations hazardous to the public or its policyholders.

(b) The above information shall be filed with the Commissioner at:

Attention: Reinsurance Accreditation
Division of Financial Examinations
Department of Insurance
20 West State Street
CN325
Trenton, New Jersey 08625

(c) An initial application for accreditation shall be deemed approved unless the Commissioner transmits a letter to the filer, within 120 days from the date of the filing of the completed application identifying the reasons upon which the Commissioner has denied the filer's accreditation. Where a filing is deemed approved, the initial approval shall be valid until August 31. If the initial approval is issued after June 1, it shall be deemed valid until August 31, of the following year.

(d) A reinsurer shall apply for renewal of its accreditation annually at the address in (b) above, to the attention of "Renewal Reinsurance Accreditation." The reinsurer shall file its application for renewal no later than June 1 of any year in which it seeks to continue its accreditation and shall submit updated information as required in (a) above.

(e) A renewal filed in accordance with the above shall be deemed approved unless denied by the Commissioner prior to August 31.

(f) An accredited reinsurer shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

1. Any limitation on its ability to write new or renewal business;
2. Any delinquency proceedings;
3. The suspension, revocation or nonrenewal of its certificate of authority in any state or jurisdiction;
4. An order or any action by any state or jurisdiction which requires it to cease writing new or renewal business; or
5. Any action by any state or jurisdiction requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

(g) Where the Commissioner determines that an assuming insurer has failed to maintain any of the qualifications set forth in (a)1 through 7 and (f) above, after written notice and opportunity for a hearing in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., the Commissioner may revoke or refuse to renew the assuming insurer's accreditation.

(h) The Department shall promulgate annually on October 31, a list of accredited reinsurers. The list shall be published in the New Jersey Register as a public notice.

(i) An insurer shall be prohibited from reporting a credit with respect to reinsurance ceded after 90 days from the date an assuming insurer has had its accreditation denied, revoked or nonrenewed.

11:2-28.5 Reinsurer domiciled and licensed in another state or jurisdiction which employs substantially similar standards to this subchapter

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement:

1. Is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer, is entered through and licensed in, a state which employs substantially similar standards regarding credit for reinsurance to those set forth in this subchapter;
2. Submits a non-refundable filing fee of $250.00 made payable to Treasurer, State of New Jersey;
3. Files with the Commissioner a certified copy of a certificate of authority, a certificate of compliance or an equivalent document which has been properly notarized as evidence that it is licensed to transact insurance or reinsurance in its state of domicile or, in the case of a United States branch of an assuming alien insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;
4. Files with the Commissioner a properly executed form AR-1 (see Appendix) as evidence that it submits to this State's jurisdiction and authority to examine its books and records;
5. Files with the Commissioner a certification executed by an authorized officer of the reinsurer which certifies that the reinsurer's condition and method of operations are financially sound and will not render its operations hazardous to the public or its policyholders as determined by the factors set forth at N.J.A.C. 11:2-27.4. The officer shall certify that:

i. For a life and health assuming insurer, that:

(1) Its policy reserves are adequate; and

(2) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(3) Its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, and attaches any and all documents in support thereof;

ii. For a property and casualty assuming insurer, that net premium written to surplus as to policyholders does not exceed a 3:1 premium to surplus ratio and loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio as of the date of the certified balance sheet from its most recent annual statement; and

iii. Except for reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system, that it maintains a surplus as regards policyholders in an amount not less than $20,000,000;

6. A reinsurer shall append to the certification set forth in (a)5 above, a certified balance sheet from the reinsurer's most recent annual statement;
7. Within 90 days from the date of receipt of the completed filing, the filing shall either be deemed approved or the Commissioner shall transmit a letter to the filer which identifies the reasons upon which the Commissioner has found that either the reinsurer's state or jurisdiction of domicile does not employ substantially similar standards or the reinsurer otherwise fails to satisfy the requirements of this subchapter;
8. A reinsurer authorized pursuant to this section shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

i. Any limitation on its ability to write new or renewal business;

ii. Any delinquency proceedings;

iii. A suspension, revocation or nonrenewal of its certificate of authority in any state or jurisdiction;

iv. An order or any action by any state or jurisdiction which requires it to cease writing new or renewal business; or

v. Any action, by any state or jurisdiction, requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

9. The above information shall be filed with the Commissioner at:

Attention: Reinsurance—Similar Standards
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

11:2-28.6 Reinsurer maintaining trust funds

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where as of the date of the ceding insurer's statutory financial statement the assuming insurer meets the standards set forth in (a)1 and 2 below, in accordance with the procedures set forth in (a)3 through 8 below:

1. The assuming insurer maintains a trust fund in an amount prescribed in (b) below in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest.

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2. The assuming insurer files with the Commissioner a letter requesting authorization to provide reinsurance. The letter shall specify: that the reinsurer seeks authorization based on the fact that it maintains trust funds for the benefit of its ceding insurers and United States policyholders; the location of the trust funds; and a list of documents and information submitted therewith and upon which the assuming insurer shall rely in connection with its request for authorization. The reinsurer shall submit to the Commissioner the following:

i. A nonrefundable filing fee made payable to Treasurer, State of New Jersey of $1,000 for an initial filing and $1,000 for a renewal filing;

ii. A properly executed form AR-1;

iii. A description of which categories of insurance are effected by the cessions;

iv. A certification executed by an authorized officer of the reinsurer which certifies that the reinsurer's condition and method of operations are financially sound and will not render its operations hazardous to the public or its policyholders as determined in accordance with the factors set forth at N.J.A.C. 11:2-27.4. The officer shall certify:

(1) For a life and health assuming insurer, that:

(A) Its policy reserves are adequate;

(B) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(C) Its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, together with any and all documents in support thereof;

(2) For a property and casualty assuming insurer, that net premium written to surplus as to policyholders does not exceed a 3:1 premium to surplus ratio and loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio as of the date of the certified balance sheet from its most recent annual statement; and

(3) To the accuracy of the information required by (b) below;

v. A certified balance sheet from the reinsurer's most recent annual statement; and

vi. A list of the assets of the trust certified by the trustee.

3. The information in (a)1 and 2 shall be filed with the Commissioner at:

Attention: Reinsurance Trust Fund
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

4. A reinsurer shall reapply for authorization annually at the address set forth in (a)3 above no later than June 1 of each year.

5. Within 30 days from receipt of the information in (a)1 and 2 above the Commissioner shall notify the filer of any deficiencies in its submission and the filer shall have 30 days to cure such deficiencies.

6. Within 90 days from the date of receipt of the completed filing, the filing shall either be deemed approved or the Commissioner shall transmit a letter to the filer which identifies the reasons upon which he or she has relied to determine that the filer has not met the requirements of this section and that insurers shall be prohibited from reporting credits for reinsurance for insurance ceded to the filer.

7. A reinsurer authorized pursuant to this section shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

i. Any limitation on its new or renewal business;

ii. Any delinquency proceedings;

iii. Its certificate of authority is suspended, revoked or nonrenewed in any state or jurisdiction;

iv. An order has been entered or any action has been taken by any state or jurisdiction which requires it to cease writing new or renewal business; and

v. Any action, by any state or jurisdiction, requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

8. An assuming insurer shall report annually to the Commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers to be evaluated by the Commissioner, including, but not limited to: a recent actuarial opinion which certifies to the adequacy of the loss and loss adjustment expense reserve liabilities, and, where applicable, life and health reserve liabilities, in order to determine the sufficiency of the trust fund; and any additional information the Commissioner deems necessary to ensure that the assuming insurer's condition and method of operation are not such as would render its operations hazardous to the public or policyholders in this State.

(b) In order to qualify as a reinsurer as provided in (a) above, an assuming insurer shall establish a trust fund. The trust fund established by the assuming insurer shall meet the following standards based upon the following category of assuming insurer into which it falls:

1. The trust fund for a single assuming insurer shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and, in addition, a trusteed surplus of not less than $20,000,000.

2. The trust fund for a group of insurers, which group includes individual unincorporated underwriters, shall consist of a trusteed account representing the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the Commissioner an annual certification of the solvency of each underwriter for the fiscal period immediately preceding, which fiscal period shall not be less than one year, by the group's domiciliary regulator and its independent certified public accountant.

3. The trust fund for a group of incorporated insurers under common administration which complies with the filing requirements set forth in this section whose members possess aggregate policyholder's surplus of $10,000,000,000, calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC, and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the group's several liabilities pursuant to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which not less than $100,000,000 shall be held jointly and exclusively for the benefit of the United States ceding insurers of any member of the group. The group shall file a properly executed form AR-1 as evidence of its submission to this State's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the Commissioner annual certifications by the members' domiciliary regulators and their independent certified public accountants of the solvency of each member of the group for the fiscal period immediately preceding which fiscal period shall not be less than one year.

(c) The trust required by (b) above shall be established in a form approved by the Commissioner and in compliance with this section, and the content, location, legal currency and financial institutions shall be acceptable to the Commissioner. The trust instrument shall provide that:

1. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States;

2. Legal title to the assets of the trust shall be vested in the trustees of the trust for the benefit of the grantor's United States

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policyholders and ceding insurers, their assignees and successors in interest;

3. The trust shall be subject to examination as determined by the Commissioner;

4. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations due under reinsurance agreements subject to the trust;

5. No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding year's end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

i. The trust assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender) investments of stocks and bonds listed by the NAIC's Securities Valuation Office or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the grantor, beneficiary, parent, subsidiary or an affiliate of either the grantor or the beneficiary; and

6. No amendment to the trust shall be effective unless filed with and approved in advance by the Commissioner.

11:2-28.7 Credit for reinsurance required by law

(a) An insurer may be permitted to take a credit for reinsurance ceded to an assuming insurer which does not meet any of the requirements set forth at section 11:2-28.3, 28.4, 28.5 or 28.6, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required or provided by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

(b) A credit may taken for insurance ceded by a domestic insurer to a state owned or controlled insurance or reinsurance companies or a ceding company participating in pools, guaranty funds or joint underwriting associations required by statute, regulation or administrative order.

11:2-28.8 Reduction from liability for reinsurance ceded to an unauthorized assuming insurer

(a) An insurer shall be permitted to take a reduction from liability for reinsurance ceded to an assuming insurer not meeting the requirements of N.J.A.C. 11:2-28.3, 28.4, 28.5, 28.6 or 28.7 in an amount which does not exceed the liabilities carried by the ceding insurer. Such reduction shall be in the amount of the funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security shall be held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer, or in the case of a trust held in a qualified United States financial institution, subject to withdrawal solely by and under the exclusive control of the ceding insurer.

(b) The security shall be in the form of:

1. Cash (United States legal tender);

2. Securities listed by the Securities Valuation Office of the NAIC and qualified as admitted assets;

3. Clean, irrevocable, evergreen, unconditional letters of credit issued or confirmed by a qualified United States institution no later than December 31st of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming qualified United States financial institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs, unless the issuer has been declared insolvent under applicable statutory or regulatory provisions; or

4. Any other form of security approved by the Commissioner upon formal request.

11:2-28.9 Trust agreements qualified pursuant to N.J.A.C. 11:2-28.8

(a) An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to N.J.A.C. 11:2-28.8 shall be permitted only when the requirements set forth below and in N.J.A.C. 11:2-28.10 and 28.11 are met.

1. The beneficiary, the grantor and a trustee shall enter into a trust agreement. The trustee shall be a qualified United States financial institution.

2. The trust agreement shall create a trust account into which the trust's assets shall be deposited.

3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this section. If the Commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in 4i below must also be presentable, as a matter of legal right, at the trustee's principal office in the United States. The trust assets shall consist of cash (United States legal tender), certificate of deposit (issued by a United States bank and payable in United States legal tender), investments of stocks and bonds listed by the NAIC's Securities Valuation Office, or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or an affiliate of either the grantor or the beneficiary.

4. The trust agreement shall provide that:

i. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustees;

ii. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

iii. It is not subject to any conditions or qualifications outside of the trust agreement; and

iv. It shall not contain references to any other agreements or documents except as provided below in (a)11 below.

5. The trust agreement shall be established for the benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

i. Receive assets and hold all assets in a safe place;

ii. Determine that all assets are in such form that the beneficiary or the trustee, upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

iii. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

iv. Notify the grantor and the beneficiary within ten days, of any deposits to or withdrawals from the trust account;

v. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

vi. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of, but with notice to, the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

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8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established and shall at minimum conform to the standards set forth in these rules.

9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

10. The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

11. Notwithstanding other provisions of this subchapter, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer or the inability of the ceding insurer to pay all or any part of a claim, for the following purposes:

i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid or owed by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

ii. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

iii. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in (a)11i and (a)11ii above as may remain executory after such withdrawal and for any period after the termination date.

12. The trust agreement shall provide that the trustee shall resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(b) The trust agreement may provide for the following conditions:

1. That the grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends may be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name;

2. That the trustee may have the authority to invest and accept substitutions of any funds in the account, provided that no investment or substitution may be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in (c)1ii below;

3. The beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets; and

4. Upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(c) A reinsurance agreement may provide provisions to be included in a trust agreement and the trust account established thereunder.

1. A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

i. The assuming insurer may enter into a trust agreement and may establish a trust account for the benefit of the ceding insurer and specify what the agreement is to cover;

ii. Assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of stocks and bonds listed by the NAIC's Securities Valuation Office or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the grantor, beneficiary, parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement shall specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

iii. The reinsurance agreement entered into in conjunction with the trust agreement may, but need not include the provisions required by (c)1ii above, so long as the conditions required in (a) above are included in the trust agreement.

iv. The assuming insurer, prior to depositing assets with the trustee, shall execute assignments or endorsements in blank, or transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may, whenever necessary, negotiate these assets without consent or signature from the assuming insurer or any other entity;

v. All settlements of account between the ceding insurer and the assuming insurer shall be made in cash or its equivalent; and

vi. The assuming insurer and the ceding insurer shall agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer or the inability of the ceding insurer to pay all or any part of a claim, only for the following purposes:

(1) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(2) To reimburse the ceding insurer or pay an insolvent ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer or owed by an insolvent ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(3) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceded insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred, including losses incurred but not reported, loss adjustment expenses and unearned premium reserves; and

(4) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

2. The reinsurance agreement may also contain provisions that:

i. The assuming insurer may seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust

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assets and transfer those assets to the assuming insurer, and the ceding insurer shall not unreasonably or arbitrarily withhold its approval provided:

(1) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(2) After withdrawal and transfer, the market value of the trust account is no less than 102 percent of the required amount;

ii. Any amount withdrawn in excess of the actual amounts required for (c)1vi(1), (2) and (3) or in the case of (c)1vi(4) any amounts that are subsequently determined not to be due shall be returned;

iii. Interest shall be paid at a rate not in excess of the prime rate of interest as reported in the Federal Reserve Bulletin, on the amounts held pursuant to subsection (c)1vi(3); and

iv. An award by any arbitration panel or court of competent jurisdiction shall be permitted for:

(1) Interest at a rate different from that provided in iii above;

(2) Court of arbitration costs;

(3) Attorney's fees; and

(4) Any other reasonable expenses.

3. The reinsurance agreement shall contain a provision, if applicable, which requires that a reinsurance intermediary:

i. Is a fiduciary for the reinsurer; and

ii. Shall hold any and all funds collected on the reinsurer's behalf, in a fiduciary capacity, in a qualified United States financial institution.

(d) A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer as reflected in financial statements required to be filed with the Department in compliance with the provisions of this subchapter when established on or before the date of filing of the financial statement of the ceding insurer. The reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(e) Any trust agreement or underlying reinsurance agreement in existence prior to August 16, 1993 shall be acceptable until February 12, 1994, at which time any and all trust agreements shall comply with this subchapter.

(f) The failure of any trust agreement to specifically identify the beneficiary shall not be construed to affect any actions or rights which the Commissioner may take or possess pursuant to the provisions of the laws of this State.

11:2-28.10 Letters of credit qualified pursuant to N.J.A.C. 11:2-28.8

(a) A letter of credit shall be clean, irrevocable, evergreen, and unconditional and issued or confirmed by a qualified United States financial institution. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. The letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in (i)1 below. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, conservator, rehabilitator or liquidator.

(b) The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(c) The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(d) The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice to the named beneficiary from the issuing financial institution. The "evergreen clause" shall provide for a period of no less than 30 days' notice prior to expiry date or nonrenewal.

(e) The letter of credit shall state whether it is subject to and governed by the laws of this State or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, Publication 400 or any subsequent revisions, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

1. Publication 400 can be obtained by contacting ICC Publishing, Inc. at (212) 206-1150 or by writing to it at 156 Fifth Avenue, STE 820, New York, New York 10010 and remitting the appropriate fees.

(f) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, Publication 400, then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 400 occur.

(g) The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit in accordance with these rules.

(h) Where a letter of credit is issued by a United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in (g), the following additional requirements shall be met:

1. The issuing United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

2. The "evergreen clause" shall provide for 30 days' notice to the named beneficiary or its successors in interest from the issuing financial institution prior to expiry date or nonrenewal.

(i) A reinsurance agreement, in conjunction with which a letter of credit is obtained, may contain the following provisions:

1. The assuming insurer shall provide letters of credit to the ceding insurer and specify what they are to cover.

2. The assuming insurer and ceding insurer shall agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

i. To reimburse the ceding insurer or to pay an insolvent ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

ii. To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer or owed by an insolvent ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

iii. To fund an account with the ceding insurer in an amount at least equal to the deduction for reinsurance ceded from the ceding insurer's liabilities for policies ceded under the agreement. Such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves; or

iv. To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

3. The provisions of (i)1 and 2 above shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

4. Nothing contained in (i)1 and 2 above shall preclude the ceding insurer and assuming insurer from providing for:

i. An interest payment, at a rate not in excess of the prime rate of interest as reported in the Federal Reserve Bulletin, on the amounts held pursuant to (i)2iii above; or

ii. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the

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case of (i)2iv above, any amounts that are subsequently determined not to be due.

5. When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of (i)2 above, require that the parties enter into a "Trust Agreement" which may be incorporated into the reinsurance agreement or be a separate document.

(j) A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer as reflected in financial statements required to be filed with the Department unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. The reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

11:2-28.11 Other security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States in connection with the reinsurance contract under which those funds are withheld, subject to withdrawal solely by the ceding insurer and under its exclusive control.

11:2-28.12 Reinsurance contract

(a) Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of N.J.A.C. 11:2-28.3, 28.4, 28.5, 28.6, or 28.8 unless the reinsurance agreement:

1. Includes a proper insolvency clause which provides that in the event of the insolvency of the ceding insurer, reinsurance proceeds will be paid to the ceding insurer or its liquidator, rehabilitator, receiver or other statutory successor on the basis of the amount of the claim allowed in the insolvency proceeding, without diminution by reason of the inability of the ceding insurer to pay all or any part of the claim, except that credit is allowed:

i. Where the contract specifically provides for another payee of such reinsurance, acceptable to the Commissioner, in the event of the insolvency of the ceding insurer; and

ii. Where the assuming insurer, with the consent of the direct insured or insureds, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the insureds under such policies and in substitution for the obligations of the ceding insurer to such insureds; and

2. Includes a provision whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

(b) The insolvency clause shall include the following provisions:

1. The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement;

2. In the event of insolvency and the appointment of a rehabilitator, conservator, liquidator or statutory successor of the ceding company, the reinsurance obligation shall be payable to such rehabilitator, conservator, liquidator or statutory successor immediately upon demand, with reasonable provision for verification, on the basis of claims allowed against the insolvent company by any court of competent jurisdiction or by any conservator, liquidator, or statutory successor of the company having authority to allow such claims, without diminution because of such insolvency or because such rehabilitator, conservator, liquidator or statutory successor has failed to pay all or a portion of any claims. Payments by the reinsurer as set forth above shall be made directly to the ceding insurer or to its rehabilitator, conservator, liquidator or statutory successor;

3. The rehabilitator, conservator, liquidator or statutory successor of a ceding insurer shall give written notice of the pendency of a claim against the ceding insurer indicating the policy or bond reinsured, within a reasonable time after such claim is filed. The receiver, rehabilitator, conservator or liquidator of an insolvent ceding company shall seek to arrange for the giving of notice of the pendency of claims on reinsured policies by the liquidator or by guaranty funds or by other persons responsible for the adjustment and settlement of the insolvent ceding company claims. Failure to give such notice shall not excuse the obligation of the reinsurer unless it is substantially prejudiced thereby. If no part of the claim is covered by a guaranty association act or similar act, the reinsurer may interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defense or defenses which it may deem available to the ceding company or its conservator, liquidator or statutory successor. The expense thus incurred by the reinsurer shall be payable subject to court approval, out of the estate of the insolvent ceding insurer as part of the expense of conservation, rehabilitation, or liquidation to the extent of a proportionate share of the benefit which may accrue to the ceding insurer in conservation, rehabilitation, or liquidation, solely as a result of the defense undertaken by the reinsurer; and

4. Payments by the reinsurer shall be made directly to the ceding insurer to its conservator, liquidator or statutory successor, except where the contract of insurance or reinsurance specifically provides another payee for such reinsurance in the event of insolvency of the ceding insurer.

11:2-28.13 Contracts affected

All new and renewal reinsurance transactions entered into after February 5, 1994 shall meet the standards set forth in this chapter if credit is to be given to the ceding insurer for such reinsurance.

APPENDIX

FORM AR-1
CERTIFICATE OF ASSUMING INSURER

I,_____ ,_____ of
(name of officer) (title of officer)

_____ , the assuming insurer
(name of assuming insurer)
under a reinsurance agreement(s) with one or more insurers domiciled

in_____, hereby certify that
(name of state)

_____ ("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in

_____ for the adjudication of any
(ceding insurer's state of domicile)
issues arising out of the reinsurance agreement(s), agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement(s) to arbitrate their disputes if such an obligation is created in the agreement(s).

2. Designates the Insurance Commissioner of

_____ as its lawful
(ceding insurer's state of domicile)
attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement(s) instituted by or on behalf of the ceding insurer.

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3. Submits to the authority of the Insurance Commissioner of _____ to examine its
(ceding insurer's state of domicile)
books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in _____ reinsured by Assuming
(ceding insurer's state of domicile)
Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated:_____ _____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

REG11228/LRWPC

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Risk Retention Groups and Purchasing Groups

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:2-36

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.449.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), and P.L. 1993, c.240 (enacted August 9, 1993).

Concurrent Proposal Number: PRN 1993-512.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason, Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with the normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted rules will become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The agency emergency adoption and concurrent reproposal follows:

Sumamry

The Department of Insurance ("Department") is proposing a series of new rules as part of the National Association of Insurance Commissioner's ("NAIC") Financial Regulation and Accreditation Program. The NAIC Accreditation Program provides specific laws, regulations, practices and procedures that the NAIC believes all states need to have in place to adequately monitor the financial condition of insurers. In order to receive NAIC Accreditation, a state's compliance is reviewed and evaluated by an independent audit team.

If New Jersey is not accredited by Janaury 1, 1994, any state which is accredited will not accept examinations of New Jersey domestic insurers conducted by this Department. The number of New Jersey domestics that would be impacted by failure to obtain NAIC accreditation is: 27 property/casualty insurers and 12 life or health insurers.

In an effort to obtain NAIC accreditation by January 1, 1994, the Department is adopting and concurrently proposing new rules to implement the provisions of P.L. 1993, c.240, the "New Jersey Risk Retention Act," which regulate risk retention groups and purchasing groups.

A risk retention group is a corporation or other limited liability association which is licensed as an insurance company in at least one state of the United States. A purchasing group is formed by a group of persons with similar exposure to risk which purchases liability insurance for its group members.

These proposed rules will enable the Commissioner of Insurance to regulate the conduct of risk retention groups and purchasing groups doing business in this State, and to ensure that they are in compliance with applicable laws of this State, to the extent such laws are not preempted by 15 U.S.C. §3901 et seq.

These rules require risk retention groups and purchasing groups to submit to the Department a statement of registration and a Notice of Appointment.

Proposed N.J.A.C. 11:2-36.1 states the purpose and scope of these rules.

Proposed N.J.A.C. 11:2-36.2 provides the definitions of terms used in this subchapter.

Proposed N.J.A.C. 11:2-36.3 provides the registration requirements for risk retention groups.

Proposed N.J.A.C. 11:2-36.4 provides additional risk retention groups requirements.

Proposed N.J.A.C. 11:2-36.5 provides the Notice and registration requirements for purchasing groups.

Proposed N.J.A.C. 11:2-36.6 provides the fines and penalties for violating provisions of this subchapter.

Social Impact

These rules are based on P.L. 1993, c.240, the New Jersey Risk Retention Act, and provide a regulatory framework which will enable the Commissioner of Insurance to the extent possible to identify and determine bona fide risk retention and purchasing groups. These rules regulate the conduct of risk retention groups and purchasing groups doing business in this State, and to ensure that they are in compliance with applicable laws of this State. These rules also protect members of purchasing groups because these rules require purchasing groups to use insurance carriers and producers that are recognized in this State, and ensure greater disclosure of the financial condition of the risk retention and purchasing group.

Economic Impact

These rules will enable the Commissioner of Insurance to regulate the conduct of risk retention groups and purchasing groups doing business in this State, and to ensure that they are in compliance with applicable laws of this State.

The Department believes that no adverse economic impact should be experienced by risk retention groups on purchasing groups. These proposed new rules do not impose any additional fees for risk retention groups or purchasing groups which are registering in this State in accordance with this subchapter. The Department does not anticipate that these rules will add any additional costs to risk retention groups or purchasing groups doing business in this State in order to complete the information required by these rules (for example, the statement identifying the state(s) in which the group is chartered or the copy of its plans of operation). Since policyholders are owners the Department does not anticipate these groups incurring additional costs to adhere to the notification requirements of these rules.

Moreover, as noted in the proposal Summary above, these amendments are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed new rules. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the

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implementation of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

The proposed new rules may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These proposed new rules impose compliance requirements on risk retention groups and purchasing groups registered in this State pursuant to this subchapter.

These proposed new rules do not impose any additional fees for risk retention groups or purchasing groups which are registering in this State in accordance with this subchapter. Since policyholders are owners the Department does not anticipate these groups incurring additional costs to adhere to the notification requirements of these rules.

These rules also require all risk retention groups and purchasing groups which wish to be registered in this State to submit a Statement of Registration and Notice of Appointment. In order to effectuate the goals of these rules, no differentiation in requirements based upon business size can be provided or is authorized by P.L. 1993, c.240.

Full text of the emergency adopted and concurrently proposed new rules follows:

SUBCHAPTER 36. RISK RETENTION GROUPS AND PURCHASING GROUPS

11:2-36.1 Purpose and scope

(a) The purpose of this subchapter is to regulate in this State the formation and/or operation of:

1. Foreign or alien risk retention groups; and

2. Purchasing groups formed in the United States pursuant to 15 U.S.C. §3901 et seq.

(b) This subchapter applies to:

1. All foreign or alien risk retention groups and their legal representatives, who are doing or intend to do business in this State; and

2. All purchasing groups with members located in this State and their legal representatives, who are doing or intend to do business in this State.

11:2-36.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Doing business in this State" means solicitation in this State, having group members in this State, or having an office in this State.

"Domicile" means, with respect to a purchasing group: for a corporation, the state in which the purchasing group is incorporated; for an unincorporated entity, the state of its principal place of business.

"Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance and any other arrangement for shifting and distributing risk which is determined to be insurance pursuant to the laws of the State.

"Liability" means legal liability for damages, including the cost of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of: any profit or non-profit business, trade, product, services, including professional services, premises, or operations; or any activity of any state or local government or any agency or political subdivision thereof, but does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the Federal "Employers' Liability Act," 45 U.S.C. §51 et seq.

"Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of the risk retention group, including: information sufficient to verify that its members are engaged in business or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer; historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available; pro forma financial statements and projections; appropriate opinions by a qualified actuary, including the determination of minimum premium or participation levels and capitalization required to commence operations and to prevent a hazardous financial condition, which shall be in the format and otherwise satisfy all requirements established by the Commissioner for loss reserve actuarial opinions required to be submitted by licensed property and casualty insurers in this State; identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements; identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

"Purchasing group" means any group which has as one of its purposes the purchase of liability insurance on a group basis; purchases such insurance only for its group members and only to cover their similar or related liability exposure; is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and is domiciled in this or any other state.

"Risk retention group" means any corporation or other limited liability association: which is organized for the primary purpose of, and whose primary activity consists of, assuming and spreading all, or any portion, of the liability exposure of its group members; which is chartered and licensed as a liability insurance company and is authorized to engage in the business of insurance under the laws of any state, or prior to January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands, and before that date, certified to the commissioner of insurance, or other appropriate official, of at least one state that it satisfied the capitalization requirements of that state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as defined in the Federal "Product Liability Risk Retention Act of 1981," Pub. L. 97-45 (15 U.S.C. §3901 et seq.), before October 27, 1986; which does not exclude any person from membership in the group solely to provide for members of that group a competitive advantage over such a person; which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group, or has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and its owners are the only persons who comprise the membership of the risk retention group and who are provided insurance by such group; whose members are engaged in businesses or activities similar or related with respect to the liability to which those members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; whose activities do not include the provision of insurance, other than liability insurance for assuming and spreading all or any portion of the liability of its group members, and reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any member of any other group, which is engaged in businesses or activities so that this group or member meets the requirement that members are engaged in businesses or activities similar or related with respect to the liability to which those members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations for membership in the risk retention group which provides the reinsurance; and the name of which includes the phrase "risk retention group."

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11:2-36.3 Risk retention group registration requirements

(a) No risk retention group shall do business in this State as a risk retention group until it has complied with the requirements of this subchapter and received Notice of Registration from the Department.

(b) Any risk retention group which is chartered and licensed under the laws of any other state and which wishes to do business in this State shall submit to the Department.

1. A copy of its certificate of authority or license authorizing it to transact business as an insurance company, certified by the state of domicile;

2. A statement identifying the state(s) in which the risk retention group is chartered and licensed as a liability insurance company, the date of its charter and admission as a licensed insurer and its principal place of business, and any other information, including information regarding its membership. Additionally, the statement shall include the following:

i. The identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;

ii. The amount and nature of initial capitalization;

iii. The coverages to be afforded; and

iv. The states in which the group intends to operate;

3. A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to the state or states in which the risk retention is chartered and licensed in accordance with P.L. 1993, c.240;

4. A statement of registration (as set forth in Appendix A and incorporated herein by reference) and a Notice of Appointment (as set forth in Appendix B and incorporated herein by reference), which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process; and

5. Payment of the $100.00 registration filing fee which shall accompany the statement of registration, in accordance with N.J.A.C. 11:1-32.

(c) Any risk retention group currently registered with the Department prior to August 16, 1993 shall submit a statement of registration (as set forth in Appendix A) and a Notice of Appointment (as set forth in Appendix B). The registration must be filed no later than November 8, 1993. The risk retention group shall notify the Department of any change in the information in the statement of registration within 30 days of any change.

(d) Each foreign and alien risk retention group which has received a certificate of registration from the Department to do business in this State shall submit to the Department:

1. On or before March 1, or as prescribed by the state of domicile, a statement of financial condition for the proceeding calendar year ended December 31. The statement shall be on a form as prescribed by the state of domicile;

2. On or before June 1, a statement of opinion on loss or loss adjustment expense reserves made by a member of the American Academy of Actuaries, or a qualified loss reserve specialist;

3. By June 30, a report of financial condition, certified by an independent public accountant;

4. Within 30 days after filing in its state of domicile, a copy of each examination of the risk retention group as certified by the chartering state's commissioner or public official conducting the examination;

5. Upon request of the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

6. Such information as may be required to verify its continuing qualification as a risk retention group under N.J.A.C. 11:2-36.2, including, but not limited to:

i. A listing of all members participating in the risk retention group, and a certification of an officer that the group is composed of members whose business or activities are similar or related with respect to liability; and

7. Payment of the $100.00 Annual Statement filing fee in accordance with N.J.A.C. 11:1-32.

(e) Failure by any currently registered risk retention group either to file a statement of registration, to complete all information requested pursuant to this subchapter or to update changes in the statement of registration may result in suspension or forfeiture of the risk retention group's registration status with the Department.

(f) Any person wishing to establish a risk retention group chartered and licensed to write only liability insurance in this State shall, in addition to meeting the requirements pursuant to N.J.S.A. 17:17-1 et seq., submit to the Department a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days of any such change. The group shall not offer any additional kinds of liability insurance in this State, or in any other state, until a revision of such plan or study is approved by the Commissioner. Additionally, the risk retention group shall adhere to the requirements of P.L. 1993, c.240 and (b)1 through 5 above.

(g) Each risk retention group, its agents and representatives shall comply with the Unfair Claims Settlement Practices Act of this State, N.J.S.A. 17:29B-1 et seq., and any other State law regarding deceptive, false or fraudulent acts or practices.

(h) Each risk retention group must submit to an examination by the Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after a request by the Commissioner of this State. The risk retention group shall pay the reasonable expenses of such an examination upon presentation by the Commissioner of a detailed account of the expenses.

(i) Each risk retention group shall comply with any lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the Commissioner if there has been a finding of financial impairment after an examination pursuant to this section.

(j) Each risk retention group shall comply with any injunction issued by a court of competent jurisdiction upon a petition by the Commissioner alleging that the group is in a hazardous financial condition or is financially impaired.

11:2-36.4 Additional risk retention groups requirements

(a) Any risk retention group which is registered in this State and chartered and licensed under the laws of any other state and which wishes to do business in this State, in addition to the requirements of N.J.A.C. 11:2-36.3, shall distribute its annual statement of operations to its members.

11:2-36.5 Notice and registration requirements of purchasing groups

(a) No purchasing group shall do business in this State as a purchasing group until it has complied with the requirements of this subchapter and received notification from the Department that it has been registered to do business in this State.

(b) Any group of persons with similar exposure to risk may form a purchasing group for the purpose of purchasing liability insurance.

1. Any purchasing group with members located in this State shall submit to the Department a statement of registration (as set forth in Appendix C and incorporated herein by reference) and a Notice of Appointment (as set forth in Appendix D and incorporated herein by reference) which shall be accompanied by a registration fee in accordance with N.J.A.C. 11:1-32.

2. Each purchasing group registered pursuant to this section shall submit to the Department from time to time, as it may require, reports relative to the group's operations.

3. Each purchasing group with members in this State registered pursuant to this subsection is subject to audits or examination as the Commissioner may deem necessary.

(c) Any purchasing group which was doing business in this State prior to August 16, 1993 shall submit to the Department a statement of registration (as set forth in Appendix C) and a Notice of Appointment (as set forth in Appendix D). The statement of registration must be filed no later than November 8, 1993. The purchasing group

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shall notify the Commissioner of any change in the information in the statement of registration within 30 days of any change.

(d) Failure of any currently registered purchasing group either to file a statement of registration, to complete all information requested pursuant to this subchapter or to update changes in the statement of registration, may result in suspension or forfeiture of the purchasing group's registration status with the Department.

11:2-36.6 Fines and penalties

(a) Each risk retention group, whether chartered in this State or otherwise, is subject to the same fines and penalties to which insurers licensed in this State are subject for any violation of this subchapter or any other applicable law.

(b) Failure of a risk retention group or purchasing group doing business in this State to comply with the provisions of this section may, after notice and a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, result in the revocation or suspension of its registration in this State.

APPENDIX A

STATEMENT OF REGISTRATION
STATE OF NEW JERSEY

APPLICATION FOR REGISTRATION AS
A RISK RETENTION GROUP
(All information should be typed)

1. List the corporate name of the Risk Retention Group.

_____

(Name *must* include the phrase "Risk Retention Group")

2. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of _____, and is authorized to engage in the following lines of insurance under the laws of its chartering State:

_____

_____

_____

3. Ownership of the Risk Retention Group consists of one of the following (check one):

☐ the owners of the Group are the only persons who comprise the membership of the Group and who are provided insurance by the Group;

☐ The sole owner of the Group is_____

_____

_____

(Give name and address of organization)

an organization whose members only comprise the membership of the Group, and whose owners are only persons who comprise the membership of the Group and who are provided insurance by the Group.

4. Give a general description of business or activities engaged in by Group members:

_____

_____

_____

5. List the name, address, fax number and telephone number of each officer of the Risk Retention Group and the key officer or staff person (*Not* an employee of the group's management company) responsible for overseeing "hands on management" of the group. (Attach additional pages if necessary.)

_____

_____

_____

_____

6. A. List the home office address of the Risk Retention Group:

_____

_____

_____

B. List the mailing address of the Risk Retention Group:

_____

_____

_____

7. List the name, address and telephone number of the company responsible for management of the insurance operations of this risk retention group. (If none, answer none.)

_____

_____

_____

_____

8. List the name, address and telephone number of the principal agent or broker responsible for marketing the group's insurance policies, pursuant to N.J.S.A. 17:22A-1 et seq.

Name:_____

Address:_____

Phone Number:_____

Producer ID Reference Number:_____

9. The items described below should be attached to the registration form:

A. If not previously submitted, registration fee in the amount of $100.00 made payable to the "State of New Jersey General Treasury."

B. Completed and signed Service of Process.

C. A listing of the individual(s) who organized the group and the individuals who are providing administrative services or otherwise influence or control the activities of the group.

D. A listing of current members.

As President or Chief Executive Officer of the _____, I hereby certify that the information contained in this registration is true and correct and in conformance with 15 USC 3901 et seq., N.J.S.A. 17: _____ and N.J.A.C. 11: _____. Further, I certify that:

The Risk Retention Group is composed of members who are engaged in the following described business or activities, which are similar or related with respect to the liability to which such members are exposed by virtue of related, similar, or common business, trade, product, services, premises or operations.

The primary activity of this Risk Retention Group consists of assuming and spreading all, or any portion, of the liability exposure of its members.

The Risk Retention Group is organized for the primary purpose of conducting the activity described above.

The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

The activities of the Risk Retention Group do not include the provision of insurance other than:

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(a) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and

(b) Reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities which qualify such other Risk Retention Group (or member) under item (6) above for membership in this Group.

In addition all required documents as set forth in 15 USC 3901 et seq., N.J.S.A. 17:_____ and N.J.A.C. 11:_____ are being included in this filing.

_____
President or Chief Executive Officer

_____
Secretary

Sworn before me this_____
day of_____,
19_____.

_____
Notary Public, State of:
My Commission Expires:

(Revised 7/93)

APPENDIX B

NOTICE OF APPOINTMENT OF
ATTORNEY TO ACCEPT SERVICE

STATE OF _____
DEPARTMENT OF INSURANCE

The_____, a Risk Retention Group (called the Group) duly organized under the laws of the State of _____, appoints the Insurance Commissioner of the State of _____, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Insurance Commissioner and his or her successors, full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This constitutes full compliance with Section 2(a)(1)(D) of the Liability Risk Retention Act of 1986.

The Group designates [_____] whose address is [_____] as the person to whom process against the Group served upon the Commissioner [Director, Superintendent] shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed at the City of _____, State of _____, this _____ day of _____, 19_____.

Attest:

_____ _____
Secretary (Name of Risk Retention Group)

By

_____
President

APPENDIX C

STATE OF NEW JERSEY
APPLICATION FOR REGISTRATION
AS A PURCHASING GROUP
(All information should be typed)

1. List the exact name of the Purchasing Group.

_____

_____

2. Indicate the form of organization or incorporation and date.

_____

3. The Purchasing Group is domiciled in the State of:

_____

4. List any other names under which the Purchasing Group is or may be doing business in this State or any other State if different from above.

_____

_____

5A. List the complete physical address of the Purchasing Group.

_____

_____

_____

_____

5B. List the mailing address of the Purchasing Group.

_____

_____

_____

_____

6A. List the name, title, address, fax number, and telephone number of the principal officer of the purchasing group who has knowledge of its insurance program, including membership criteria, coverages, and key personnel of the group's administrator and insurance carrier.

_____

_____

_____

_____

6B. List the name, title, address, fax number, and telephone number of the firm that acts as the administrator of the purchasing group and the name of the principal account executive responsible for the group's insurance program. (If none, answer none.)

_____

_____

_____

_____

7. List the names, addresses and occupation of the principal officers and directors of the Purchasing Group. Attach additional pages if necessary.

Principal Officers	Principal Directors

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8. Give a general description of the business or activities engaged in by purchasing group members:

_____

_____

_____

_____

9. List the lines and classification of liability insurance Purchasing Group will purchase:

_____

_____

10. What are the limits of liability including per occurrence, aggregate per participant and group aggregate.

_____

_____

_____

11. Deductible and self-insurance retentions

(a) Which are the responsibility of the individual participant?

_____

_____

(b) Which are the responsibility of the purchasing group and how funded?

_____

_____

12. List the insurance carriers from whom the Purchasing Group will purchase liability insurance described in item (9) above from. Give full name of company, state of domicile and NAIC#:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

13. Purchasing groups procuring insurance through companies licensed in New Jersey or registered Risk Retention Groups must use an insurance producer pursuant to N.J.S.A. 17:22A-1 et seq. Please identify the producer(s) representing the purchasing group:

Name_____

Address_____

Phone No._____

Producer License Reference Number: _____

14. Purchasing groups procuring insurance from New Jersey eligible surplus lines companies must place it through a licensed New Jersey insurance producer with surplus lines authority pursuant to N.J.S.A. 17:22-6.40 et seq. and 17:22A-1. Please identify the producer(s) representing the purchasing group:

Name_____

Address_____

Phone No._____

Producer License Reference Number: _____

15. List who will adjust the claims?

Name_____

Address_____

Phone No._____

Producer License Reference Number: _____

16. Has any person transacting business on behalf of this Purchasing Group ever:

(A) been arrested, indicted and convicted of a felony or is a felony charge currently pending against any such person? _____

(B) had denied any application for a professional, vocational or business license? _____

(C) has suspended or revoked any such license? _____

(D) had withdrawn or surrendered any such application or license to avoid potential disciplinary action against licensee? _____

If the answer to any part of this question is yes, attach a supplementary statement explaining in full each such occurrence.

The items described below should be attached to the registration form:

(a) If not previously submitted, registration fee in the amount of $100.00 made payable to the "State of New Jersey—General Treasury."

(b) Completed and signed Service of Process.

(c) A listing of the individual(s) who organized the Purchasing Group and the individuals who are providing administrative services or otherwise influence or control the activities of the group.

(d) A listing of current members.

- The Purchasing Group is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises or operations.
- The Purchasing Group purchases such liability insurance only for its members and only to cover their similar or related liability exposure, as described in item (8) above.
- The policy and promotional material the purchasing group will use has been forwarded along with the registration.

In addition, all required documents are set forth in 15 USC 3901 et seq., N.J.S.A. 17: _____ and N.J.A.C. 11: _____ are being included in this filing.

_____
President or Chief Executive Officer

_____
Secretary

Sworn before me this_____
day of_____,
19_____.

_____

Notary Public, State of:
My Commission Expires:

(Revised 7/93)

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APPENDIX D

NOTICE TO APPOINTMENT OF
ATTORNEY TO ACCEPT SERVICE

STATE OF NEW JERSEY

The_____, a Risk Retention Group (called the Group) duly organized under the laws of the State of _____, appoints the Insurance Commissioner of the State of _____, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Insurance Commissioner and his or her successors full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This constitutes full compliance with Section 2(a)(1)(D) of the Liability Risk Retention Act of 1986.

The Group designates [_____] whose address is [_____] as the person to whom process against the Group served upon the Commissioner [Director, Superintendent] shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed in the City of _____, State of _____, this _____ day of _____, 19_____.

Attest:

_____ _____

Secretary (Name of Risk Retention Group)

By

_____

President

(a)

DIVISION OF FINANCIAL EXAMINATIONS AND LIQUIDATIONS

Producer-Controlled Insurers

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:2-37

Emergency New Rule Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.450.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), and P.L. 1993, c.239.

Concurrent Proposal Number: PRN 1993-513.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The emergency adoption and concurrent proposal follows:

Summary

P.L. 1993, c.239 is based on a model law established by the National Association of Insurance Commissioners ("NAIC") and provides a framework by which the Department of Insurance ("Department") may regulate transactions involving insurers which are controlled by insurance producers.

The new law and these proposed new rules which will implement it are intended to meet part of the NAIC's accreditation standards and will reduce the likelihood that insolvencies will result from the activities of insurance producers who control insurers. This is accomplished by providing the Department with monitoring authority over these transactions and by imposing duties on both controlling producers and their controlled insurers.

N.J.A.C. 11:2-37.1 and 37.2 set forth the purpose and scope of these proposed new rules.

N.J.A.C. 11:2-37.3 sets forth the definitions of words and terms used in the subchapter which are also defined at P.L. 1993, c.239.

N.J.A.C. 11:2-37.4 sets forth the producer-controlled insurer information reporting requirements including reference to the report form (Appendix A) and the deadline for filing (April 1 for the calendar year immediately preceding).

N.J.A.C. 11:2-37.5 sets forth in detail the required contents of the Producer-Controlled Insurer Information Report.

N.J.A.C. 11:2-37.6 provides for confidentiality of documents and N.J.A.C. 11:2-37.7 provides for the imposition of penalties.

Social Impact

Consistent with the provisions of P.L. 1993, c.239, the proposed new rules would apply to licensed property and casualty insurers domiciled in New Jersey or in another state that is not an NAIC "accredited state" having in effect a law substantially similar to P.L. 1993, c.239. These rules would not, however, apply to "captive insurers" as defined at P.L. 1993, c.239 and N.J.A.C. 11:2-37.3.

The Department recognizes that legitimate business purposes may be accomplished through relationships wherein a producer controls an insurer and places risks with that insurer. The Department also recognizes that difficulties including conflict of interest may arise where the traditionally independent roles of producer and insurer are merged. These proposed new rules are intended to reduce the likelihood that insolvencies will result from what may be questionable activities of insurance producers who control insurers. The Department's primary objective in promulgating these rules is to protect such insurers, their shareholders and policyholders from harm.

All insurers to whom the rules apply will be required to file annually a Producer-Controlled Insurer Information Report on a form approved by the Commissioner which will provide the Department with pertinent information on producer-controlled insurers operating in New Jersey. This annual response will be required from all property/casualty insurers authorized to do business in New Jersey including those that do not qualify as producer-controlled insurers.

Reducing the likelihood of insolvency among producer-controlled insurers will inure to the benefit of all insurers, their policyholders, and taxpayers generally by contributing to the long term economic and social stability of the insurance industry in part through the lessening of exposure of the property/casualty guaranty funds.

Economic Impact

Cost of insurer compliance with the proposed rules is not expected to be substantial since insurers are already required to process and report, on a regular basis, detailed financial information concerning their operation.

As noted in the proposal Summary above, these proposed rules are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. By becoming "ac-

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credited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed rules. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the imposition of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Adoption of these rules, standing alone, is not expected to unduly affect operations of the Department or materially increase the cost thereof.

Regulatory Flexibility Analysis

The Department believes that few, if any, insurers subject to the proposed new rules are "small businesses" as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Additionally, the new rules impose no undue burden or adverse economic impact upon insurers which may qualify as "small businesses."

Small insurers can expect to incur modest additional administrative expenses, but compliance with the proposed new rules requires only minimal additional reporting and should impose little or no change in the insurers' present operations. It is anticipated that the insurers presently maintain, or otherwise provide for, all services which may be required in order to comply with the new rules. All insurers should be able to easily absorb these costs.

Because the cost of compliance with these proposed new rules is minimal, and represents no adverse economic impact upon small businesses, no exceptions for compliance by small insurers have been incorporated into the rules.

Full text of the emergency adopted and concurrently proposed new rules follows:

SUBCHAPTER 37. PRODUCER-CONTROLLED INSURERS

11:2-37.1 Purpose

The purpose of this subchapter is to implement P.L. 1993, c.239 to enable the Department to regulate transactions involving insurers which are controlled by insurance producers.

11:2-37.2 Scope

This subchapter shall apply to all licensed property and casualty insurers domiciled in this State or domiciled in a state that is not an accredited state having in effect a law substantially similar to P.L. 1993, c.239. This subchapter shall not apply to captive insurers.

11:2-37.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Accredited state" means a state in which the insurance department or other regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the NAIC.

"Captive insurer" means an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Control" or "controlled" has the same meaning as defined at N.J.S.A. 17:27A-1c.

"Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

"Controlling producer" means a producer who, directly or indirectly, controls an insurer.

"Department" means the New Jersey Department of Insurance.

"Licensed insurer" or "insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1.

"NAIC" means National Association of Insurance Commissioners.

"Producer" means any person engaged in the business of an insurance agent, insurance broker or insurance consultant as defined at N.J.S.A. 17:22A-2.

"Producer-controlled" means controlled, directly or indirectly, by a producer.

11:2-37.4 Filing of Producer-Controlled Insurer Information Report

All licensed property and casualty insurers domiciled in this State or domiciled in another state that is not an NAIC accredited state having in effect a law substantially similar to P.L. 1993, c.239, shall file an annual Producer-Controlled Insurer Information Report on a form (incorporated herein by reference as Appendix A) approved by the Commissioner. The Report shall be completed and filed with the Commissioner on or before April 1 for the calendar year immediately preceding.

11:2-37.5 Contents of the Producer-Controlled Insurer Information Report

(a) A Producer-Controlled Insurer Information Report form (Appendix A) shall be completed annually by each licensed property and casualty insurer to whom this subchapter applies and shall include the following information:

1. The name and address of the reporting insurer and any controlling producer. (A separate form should be completed and filed for each controlling producer.);

2. A certification by insurers that are not producer-controlled that they are not issuing any property and casualty insurance coverages that are or may be reportable pursuant to the provisions of P.L. 1993, c.239 or this subchapter;

3. A certification by producer-controlled insurers containing the following information:

i. The amount of the insurer's admitted assets as of September 30 of the preceding calendar year, gross premiums written during the calendar year and the percentage that gross premiums written represent of admitted assets;

ii. The amount of net premiums written during the preceding calendar year, commissions paid to the controlling producer during the calendar year and the percentage that commissions paid to the controlling producer represent of the net premiums written;

iii. Comparable amounts and percentage paid to noncontrolling producers for placement of the same kinds of insurance;

iv. An opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling producer, which loss reserve opinion shall satisfy all requirements established by N.J.A.C. 11:1-21 for loss reserve opinions required to be submitted by licensed property and casualty insurers in this State; and

v. A statement indicating whether or not the insurer's controlling producer or producers have been notified of the requirements of P.L. 1993, c.239 and these rules.

11:2-37.6 Confidentiality of documents

All documents submitted to the Commissioner pursuant to this subchapter are confidential and not public documents as defined in the Public Records Act, N.J.S.A. 47:1A-1 et seq.

11:2-37.7 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as provided by law.

APPENDIX A

PRODUCER-CONTROLLED INSURER INFORMATION REPORT FORM

Calendar Year Ending December 31, _____

Instructions: All licensed property and casualty insurers domiciled in New Jersey, or domiciled in another state that is not a NAIC "accredited state" having in effect a law substantially similar to P.L. 1993, c.239,

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are required to complete annually either Section I or Section II of this form. Section I certifies that the requirements of New Jersey Law have been reviewed and there is no controlling producer information to be reported. Section II should be completed for each producer who "controls" a reporting insurer. Completed reporting forms are due annually, on or before April 1 of each year.

SECTION I
To be completed by Insurers that are *not* Producer-Controlled

I certify that _____
(Name of Insurer)

_____
(Address of Insurer)

is not issuing any property and casualty insurance coverages that are or may be reportable pursuant to the provisions of P.L. 1993, c.239 and N.J.A.C. 11:2-37.1 et seq.

_____ _____
Date Authorized signature

_____
Title

SECTION II
To be completed by Producer-Controlled Insurers

(A separate Report Form should be completed and filed for each controlling producer.)

Calendar Year Ending December 31, _____

Name of Reporting Insurer: _____

Address: _____

Name of Controlling Producer: _____

Address: _____

1. Insurer's admitted assets as of September 30 of calendar year pursuant to P.L. 1993, c.239, §3a: $_____
2. Gross premiums written, calendar year: $_____
3. Percentage that gross premiums written represent of admitted assets: _____ %
4. Net premiums written, calendar year: $_____
5. Amount of commissions paid to controlling producer, calendar year: $_____
6. Percentage that commissions paid represent of net premiums written: _____ %
7. Comparable amounts and percentage paid to noncontrolling producers for placement of the same kinds of insurance:

   Net premiums written: $_____
   Commissions paid: $_____
   Percentage: _____ %
8. Attach the information required by P.L. 1993, c.239, § 3e: An opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling producer.
9. We have notified our controlling producer(s) of the requirements of P.L. 1993, c.239 and N.J.A.C. 11:2-37.1 et seq.

I certify that the above information is accurate and complete.

_____ _____
Date Authorized signature

_____
Title

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Increase in Property and Casualty Capital and Surplus Requirements

Adopted Emergency Rules and Concurrent Proposed Rules: N.J.A.C. 11:2-38

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.451.

Authority: N.J.S.A. 17:1C-6(e), 17:17-1 et seq. and 17:50-5.

Concurrent Proposal Number: PRN 1993-514.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason, Assistant Commissioner
Division of Legislative and Regulatory Affairs
Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625-0325

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The agency emergency adoption and concurrent proposal follows:

Summary

N.J.S.A. 17:17-1 et seq. has been amended (P.L. 1993, c.234) to increase minimum capital and surplus requirements for insurers writing property and casualty insurance in this State, and to require such insurers to maintain adequate reserves. The amendments permit those property and casualty insurers already transacting business in this State as of August 9, 1993 to request a temporary waiver, not exceeding five years, of these minimum statutory requirements. The amendments further permit the Commissioner of Insurance ("Commissioner") to subsequently increase the amount of the statutory minimum capital and surplus requirements in order to provide adequate protection against risks affecting the insurer's financial condition that are not adequately or fully covered by its reserves or other assets, but only following a formal departmental hearing unless the hearing is waived by the insurer.

These proposed new rules provide the regulatory framework whereby insurers currently transacting business may request a temporary waiver of the statutory minimum capital and surlpus requirements, and the Commissioner may subsequently require an increase in the amount of these minimum statutory requirements. These new rules are additionally part of the Department's package of legislation and rules required for NAIC accreditation.

N.J.A.C. 11:2-38.1 sets forth the purpose and scope of the proposed new rules.

N.J.A.C. 11:2-38.2 sets forth the definitions of terms used in the subchapter.

N.J.A.C. 11:2-38.3 establishes requirements for insurers currently transacting business in this State to request a temporary waiver of the statutory capital and surplus requirements. Subsection (a) permits such an insurer to apply for a two-year waiver of the requirements. Subsection (b) concerns the Commissioner's approval of a waiver request. Subsection (c) requires an insurer requesting a temporary waiver to submit a detailed proposed financial plan to the Department of Insurance for meeting the capital and surplus requirements. Subsection (d) requires the Department to notify an insurer of any deficiencies in its proposed financial plan, and the insurer to resubmit a revised plan. Subsection (e) requires an insurer to resubmit to the Department a revised financial plan addressing the deficiencies described by the Department. Subsection

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(f) establishes the confidentiality of the information contained in an insurer's financial plan. Subsection (g) permits an insurer to request an extension of a two-year waiver granted by the Commissioner not to exceed the statutory five-year compliance period. Subsection (h) provides that if an insurer fails to request a temporary waiver, the Department shall conclude that the insurer has met the statutory capital and surplus requirements. If an insurer has not, in fact, met the minimum requirements, it shall be subject to penalties.

N.J.A.C. 11:2-38.4 sets forth the procedures whereby the Commissioner may subsequently require an increase in an insurer's capital and surplus beyond the statutory minimum requirements. Subsection (a) requires the Commissioner to issue an order notifying an insurer of its capital and/or surplus deficiency and of the requirement that the insurer either submit a plan to meet the requirements or request a hearing. Subsection (b) requires an insurer in receipt of the Commissioner's order issued pursuant to (a) and not objecting to the Commissioner's determination as set forth in that order, to provide a written response to the Commissioner's order waiving its right to a hearing and submitting a proposed plan for meeting the increased requirements.

N.J.A.C. 11:2-38.5 sets forth the procedures whereby an insurer may request a formal departmental hearing on the Commissioner's determination that an insurer is required to increase its capital and surplus requirements beyond the minimum statutory requirements. Subsection (a) sets forth the procedural requirements an insurer must follow to request a hearing. Subsection (b) states that the hearing shall comply with the requirements set forth at N.J.S.A. 17:17-1 et seq. Subsection (c) states that the hearing shall be initiated within 20 days of the insurer's receipt of the Commissioner's notice informing the insurer of the capital and surplus increase requirements. Subsection (d) indicates that an order issued by the Commissioner increasing an insurer's capital and surplus requirements shall be stayed pending the outcome of the hearing. Subsection (e) requires the Department to issue a decision within 30 days of the hearing.

N.J.A.C. 11:2-38.6 sets forth the appropriate penalties for non-compliance with these rules.

Social Impact

The proposed new rules would apply to all property and casualty insurers, including reciprocal insurance exchanges, doing business in New Jersey. The rules would be beneficial to those insurers currently transacting business in this State in that the Commissioner will be permitted to temporarily waive the statutory capital and surplus minimum requirements for that group of insurers. It is additionally anticipated that increased solvency controls will provide the benefit of added security to both the policyholders of those insurers subject to these rules and to the public generally.

Economic Impact

The proposed rules will have a favorable economic impact to the extent that increased minimum capital and surplus requirements should reduce the potential for insolvency of property and casualty insurers doing business in New Jersey by early identification of those insurers unable to meet the increased requirements. Although the costs of implementing these rules will vary depending on the individual insurer, the costs involved will be outweighed by the advantage of strengthening the financial condition of insurers, as well as by the avoidance of costs that would be incurred by all policyholders contributing to the guaranty funds to ensure that claims of insolvent insurers are paid.

Moreover, as noted in the proposal Summary above, these new rules are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions are expected to be avoided under normal circumstances. This, in turn, should benefit both policyholders and insurers in continuing cost containment of regulatory expenses.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed rules. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Most of these additional costs will be defrayed through the imposition of appropriate fees and reimbursements under simultaneously proposed rules to help cover the costs of providing new services required to implement accredittion requirements.

Regulatory Flexibility Analysis

The Department believes that few, if any, insurers subject to the proposed new rules are "small businesses" as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Additionally, the new rules impose no undue burden or adverse economic impact upon insurers which may qualify as "small businesses."

Small companies can expect to incur modest additional administrative expenses, but compliance with the proposed new rules requires only minimal additional reporting and should impose little or no change in the companies' present operations. It is anticipated that the insurers presently maintain, or otherwise provide for, all services which may be required in order to comply with the new rules. All companies should be able to easily absorb these costs.

The legislation mandating the promulgation of these rules requires all insurers to meet certain minimum capital and surplus requirements, and provides no exceptions for small insurers. However, both the costs of complying with these proposed new rules and the insurers' procedural requirements have been minimized and should have little financial impact on either large or small insurers.

Full text of the emergency adopted and concurrently proposed new rules follows:

SUBCHAPTER 38. INCREASE IN PROPERTY AND CASUALTY CAPITAL AND SURPLUS REQUIREMENTS

11:2-38.1 Purpose and scope

(a) The purpose of this subchapter is to provide procedures whereby property and casualty insurers may request a temporary waiver from the minimum capital and surplus requirements set forth in P.L. 1993, c.234, sections 2 and 3. This subchapter also provides procedures whereby the Commissioner may, pursuant to P.L. 1993, c.234, section 6, subsequently require an increase in these statutory minimum requirements.

(b) This subchapter shall apply to all insurers, including reciprocal insurance exchanges, authorized, admitted or eligible to transact the business of property and casualty insurance in this State.

11:2-38.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Capital" means par value per share multiplied by the number of issued shares, or in the case of no-par shares, the total stated value.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Insurer" means any stock or mutual insurance corporation, including a reciprocal insurance exchange, authorized, admitted or eligible to transact the business of property and casualty insurance in this State pursuant to N.J.S.A. 17:17-1 et seq.

"Surplus" means the net worth of an insurer as reported in its annual statement. For a stock insurer, surplus means net worth less minimum capital. For a mutual insurer, surplus means its net worth.

11:2-38.3 Requests for temporary waiver of capital and surplus requirements

(a) An insurer transacting business in this State as of August 9, 1993 may request a two-year temporary waiver from the minimum capital and surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3, by making application in writing to the Commissioner on or before October 8, 1993. The waiver request shall be forwarded to:

New Jersey Department of Insurance
Financial Exams, Capital and Surplus Waivers
20 W. State Street
CN 325
Trenton, NJ 08625

(b) The Commissioner shall approve a temporary waiver requested pursuant to (a) above provided the insurer complies with the requirements set forth in (c) through (f).

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(c) Within 120 days of making application to the Commissioner for a temporary waiver of the statutory minimum capital and surplus requirements, the insurer shall additionally submit to the Department at the same address as set forth in (a) above, a proposed financial plan, which shall include the following:

1. The insurer's current capital and/or surplus;

2. The reason(s) for the insurer's inability to meet the minimum capital and/or surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3;

3. The insurer's proposed method and time frame for meeting the statutory minimum capital and/or surplus requirements, including the source(s) and amount(s) of additional funding;

4. A five-year projection, beginning December 31 of the following year and for the subsequent four years, of the following certified by a qualified actuary and accompanied by a narrative explaining the sources of anticipated premium and all assumptions made in developing the entire projection:

i. Assets, liabilities and surplus and other funds in the format of the Assets page and the Liabilities and Surplus and Other Funds page in the Annual Statement representing the insurer's five successive year-ends;

ii. Underwriting and investment income in the format of the Underwriting and Investment Exhibit, Statement of Income in the Annual Statement for each of the five years;

iii. The following information by line of businesss for each of the five years (the line of business classifications shall be those set forth in the Underwriting and Investment Exhibit, Part Two in the Annual Statement):

(1) Premiums earned;

(2) Losses incurred;

(3) Loss expenses incurred; and

(4) Ratios of the sum of the losses and loss expenses to premium earned;

(5) Net premiums written; and

iv. The projected values required in the Underwriting and Investment Exhibit, Part Four—Expenses in the Annual Statement; and

5. Any other information requested by the Commissioner which is relevant to the evaluation of a specific temporary waiver request.

6. In the case of a request for an extension pursuant to (g) below of a two-year waiver granted under (b) above, the insurer's proposed financial plan shall additionally include a report of the insurer's progress in meeting the minimum capital and/or surplus requirements.

(d) Upon receipt of the insurer's financial plan in (c) above, the Department shall provide the insurer with written notice of its approval of, or of any deficiencies in, the financial plan's proposed method for meeting the minimum capital and/or surplus requirements.

(e) Within 60 days of receipt of the Department's notice in (d) above informing the insurer of the deficiencies in its proposed financial plan, the insurer shall resubmit a revised financial plan correcting all deficiencies to the Department at the address set forth in (a) above.

(f) All data or information contained in the plan under (c) above is confidential and will not be disclosed by the Department to any person other than its employees and representatives.

(g) An insurer may request an extension of a two-year waiver granted by the Commissioner under (b) above not to exceed the five-year statutory compliance period set forth in P.L. 1993, c.234, sections 2 and 3 by submitting to the Department at least 90 days prior to the expiration of the two-year waiver, the items set forth in (c) above. The Department shall evaluate the insurer's extension request by following the procedures set forth in (d) through (f) above.

(h) If an insurer fails to request a temporary waiver of the minimum capital and/or surplus requirements pursuant to the procedures set forth in this section, the Department shall conclude that the insurer has met the minimum capital and/or surplus requirements. If, in fact, the insurer is unable to meet the minimum statutory capital and/or surplus requirements, the insurer shall be subject to suspension or revocation of its authority to do business in this State pursuant to P.L. 1993, c.234, section 9.

11:2-38.4 Procedures for increasing capital and surplus requirements

(a) If, upon consideration of the risks and factors set forth in P.L. 1993, c.234, sections 6 and 7, the Commissioner determines that an increase in an insurer's minimum capital and/or surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3 is required to provide adequate protection against risks affecting the insurer's financial condition that are not adequately or fully covered by its reserves or other assets, the Commissioner shall notify the insurer as follows:

1. The Commissioner shall issue an order to insurer, which shall include the following:

i. The minimum amount of capital and surplus required;

ii. The amount by which the insurer's capital or surplus is deficient; and

iii. Notice that the insurer shall either submit a plan to the Commissioner for meeting its applicable capital and surplus requirements pursuant to (b) below or request a hearing pursuant to N.J.A.C. 11:2-38.5.

(b) With the exception of requesting a hearing pursuant to N.J.A.C. 11:2-38.5, the insurer shall respond to the Commissioner's order issued under (a) above within seven days from the date of receipt of such order as follows:

1. The insurer's response to the Commissioner's order shall be in writing and shall include:

i. A waiver of the insurer's right to a departmental hearing on the Commissioner's determination; and

ii. Notice that the insurer shall submit a proposed plan to the Commissioner within 60 days from Commissioner's receipt of insurer's response in (b) above for meeting the applicable increased capital or surplus requirements.

2. The insurer's plan for meeting the applicable capital and surplus requirements shall be in writing and shall include:

i. The insurer's proposed method and time frames for meeting the increased minimum capital and/or surplus requirements, including the source(s) and amount(s) of additional funding; and

ii. A five-year projection, beginning December 31 of the following year and for the subsequent four years, certified by a qualified actuary as defined at N.J.A.C. 11:1-21 and accompanied by a narrative explaining the sources of anticipated premium and all assumptions made in developing the entire projection.

3. The insurer's five-year projection shall include:

i. Assets, liabilities and surplus and other funds in the format of the Assets page and the Liabilities and Surplus and Other Funds page in the Annual Statement representing the insurer's five successive year-ends;

ii. Underwriting and investment income in the format of the Underwriting and Investment Exhibit, Statement of Income in the Annual Statement for each of the five years;

iii. The following information by line of business for each of the five years (the line of business classifications shall be those set forth in the Underwriting and Investment Exhibit, Part Two in the Annual Statement):

(1) Premiums earned;

(2) Losses incurred;

(3) Loss expenses incurred;

(4) Ratios of the sum of the losses and loss expenses to premium earned; and

(5) Net premiums written; and

iv. The projected values required in the Underwriting and Investment Exhibit, Part Four—Expenses in the Annual Statement; and

4. Any other information requested by the Commissioner which is relevant to the evaluation of the insurer's plan to comply with increased capital and surplus requirements.

(c) The Department shall, upon receipt of the insurer's proposed plan in accordance with N.J.A.C. 11:2-38.4(b), provide the insurer with written notice of its approval of, or any deficiencies in, the proposed plan.

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11:2-38.5 Hearing requirements and procedures

(a) If an insurer is subject to an order issued by the Commissioner pursuant to N.J.A.C. 11:2-38.4(a), and the insurer objects to the actions ordered to be taken as set forth therein, the insurer may request a hearing on the Commissioner's determination within seven days from the date of receipt of such order as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the insurer should not be required to increase its capital and surplus consistent with the Commissioner's order.

(b) Pursuant to P.L. 1993, c.234, section 6, a hearing relating to the increase of capital or surplus shall be a formal departmental hearing before the Commissioner or his deisgnee, on a record, and all matters pertaining to a hearing or to an increase of capital or surplus shall be confidential and not subject to subpoena or public inspection, except as otherwise provided by N.J.S.A. 17:17-1 et seq.

(c) The Department shall initiate the departmental hearing within 20 days from the date of the insurer's receipt of the Commissioner's notice in N.J.A.C. 11:2-38.4(a) above.

(d) An Order issued by the Department pursuant to N.J.A.C. 11:2-38.4(a) above shall be stayed pending the outcome of the hearing.

(e) The Department shall issue a written hearing decision within 30 days of the hearing, which shall include the Department's findings and a determination whether the Order issued in N.J.A.C. 11:2-38.4(a) above shall be affirmed, modified or rescinded.

11:2-38.6 Fines and penalties

(a) Failure to comply with this subchapter may result in an insurer's suspension or revocation of authority to do business in the State of New Jersey.

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Increase in Capital and Surplus Requirements for Life and Health Insurers

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:2-39

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.452.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17B:32-31 et seq.; P.L. 1993, c.235 and c.245.

Concurrent Proposal Number: PRN 1993-515.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:

Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
Department of Insurance
CN-325
Trenton, New Jersey 08625-0325

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The emergency adoption and concurrent proposal follows:

Summary

New Jersey's "Dynamic Capital and Surplus Act of 1993" (P.L. 1993, c.235) increases minimum capital and surplus requirements for insurers doing life, health and annuity business in this State and authorizes the Commissioner of Insurance to adopt rules and regulations in order to provide adequate protection against risks affecting the insurer's financial condition that are not adequately or fully covered by its reserves or other assets.

This proposal tracks closely with model language adopted by the National Association of Insurance Commissioners ("NAIC") which includes a risk-based capital formula designed to identify inadequately capitalized life and health insurers. The risk-based capital is calculated by applying factors to various asset, premium and reserve items, where the factor is higher for those items with greater underlying risk and lower for less risky items. The risk-based capital is made a part of the annual report that insurers must file with the NAIC and is considered part of the NAIC's Financial Standards and Accreditation Program.

These proposed rules provide the regulatory tools necessary for regulators to use risk-based capital for life and health insurers in an appropriate fashion. Minimum capital and surplus requirements may be adequate for a new company but do not provide the cushion necessary for a growing or mature company. Since insurers vary considerably in the riskiness of their investments, operations and cash flow, capital and surplus requirements tailored to the specific needs of the insurer provide a uniform but flexible means of establishing regulatory oversight of this important subject matter.

N.J.A.C. 11:2-39.1 sets forth the purpose and scope of the proposed new rules.

N.J.A.C. 11:2-39.2 sets forth the definitions of terms used in the subchapter.

N.J.A.C. 11:2-39.3 establishes requirements relating to the "RBC Report." Subsection (a) establishes filing requirements for the RBC Report. Subsection (b) provides for the filing of an updated RBC Report. Subsection (c) provides for the filing by domestic insurers of an "NAIC RBC Report." Subsection (d) provides for regulatory treatment of an inaccurate RBC Report. Subsection (e) establishes the means of determining the new level of an insurer's capital and surplus that has been increased pursuant to these provisions.

N.J.A.C. 11:2-39.4 establishes criteria determining a "company action level event" and defines actions relating to that event. Subsection (a) sets forth conditions under which a company action level event takes place and the actions required of an insurer in such event including submission of an RBC Report. Subsection (b) sets forth when the "RBC Plan" shall be submitted. Subsection (c) sets forth actions to be taken by the Commissioner after submission including provision that the Commissioner may notify an insurer that its RBC Plan or "Revised RBC Plan" is unsatisfactory. The subsection provides that this notification may, at the Commissioner's discretion, constitute a "regulatory action level event." Subsection (d) provides for filing of an RBC Plan or a Revised RBC Plan with other states under certain specified circumstances.

N.J.A.C. 11:2-39.5 establishes criteria determining a regulatory action level event and defines actions relating to that event. Subsection (a) sets forth conditions under which a regulatory action level event takes place. Subsection (b) sets forth actions required of the Commissioner when a regulatory action level event takes place. Subsection (c) sets forth what the Commissioner may consider in determining corrective actions, and also sets forth provisions for filing an RBC Plan or a Revised RBC Plan. Subsection (d) allows the Commissioner to retain consultants.

N.J.A.C. 11:2-39.6 establishes criteria determining an "authorized control level event" and defines actions relating to that event. Subsection (a) sets forth conditions under which an authorized control level event takes place. Subsection (b) sets forth actions required of or permitted by the Commissioner when an authorized control level event takes place.

N.J.A.C. 11:2-39.7 establishes criteria determining a "mandatory control level event" and defines actions relating to that event. Subsection (a) sets forth conditions under which a mandatory control level event takes place. Subsection (b) establishes that a mandatory control level event shall require the Commissioner to take action to cause an insurer to be placed in rehabilitation or liquidation with the mandatory control level event deemed sufficient grounds for such actions.

N.J.A.C. 11:2-39.8 provides for filing of RBC Plans including required fees.

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N.J.A.C. 11:2-39.9 establishes the basis for hearings held pursuant to P.L. 1993, c.235 and these proposed rules.

N.J.A.C. 11:2-39.10 establishes confidentiality standards and prohibitions against announcements of risk based capital levels. Subsection (a) provides for the confidentiality of RBC Reports and RBC Plans. Subsection (b) prohibits publication or other dissemination of risk-based capital levels.

N.J.A.C. 11:2-39.11 establishes that the provisions of these proposed rules are supplemental to other laws of this State and do not limit powers or duties of the Commissioner under those laws.

N.J.A.C. 11:2-39.12 provides the Commissioner's authority with regard to foreign insurers. Subsection (a) requires a foreign insurer to provide an RBC Report upon request. Subsection (b) requires a foreign insurer to provide a copy of any RBC Plan or Revised RBC Plan filed in another state. Subsection (c) authorizes the Commissioner to require an RBC Plan from a foreign insurer under certain circumstances and establishes failure to file the plan as grounds for a cease and desist order. Subsection (d) authorizes the Commissioner, under certain circumstances, to make application to the Superior Court with respect to the liquidation of property of foreign insurers found in this State.

N.J.A.C. 11:2-39.13 provides for severability.

N.J.A.C. 11:2-39.14 provides for method of notice.

N.J.A.C. 11:2-39.15 sets forth waiver and phase-in provisions. Subsection (a) provides for a temporary waiver of minimum capital and surplus requirements. Subsection (b) includes phase-in provisions for RBC Reports required to be filed with respect to 1993. Subsection (c) sets forth an automatic three-year waiver of the requirement in P.L. 1993, c.235, §2 that insurers maintain their minimum capital and surplus in cash and short term assets.

Social Impact

Through promulgation of these proposed new rules, the Department intends to (1) satisfy the need for regulations implementing P.L. 1993, c.235 particularly relating to departmental hearings, waiver and phase-in provisions; and (2) establish a risk-based capital formula derived from the NAIC and designed to identify inadequately capitalized life and health insurers.

These rules, in combination with the underlying statute, provide a minimum level of capital based on the level of risk inherent in each insurer's business, at which the Commissioner must act to place an insurer under his or her control. Thus, the Commissioner will have increasing authority over a domestic insurer (and in appropriate cases over a foreign insurer) as the insurer's financial condition deteriorates.

This new, flexible approach is superior to the fixed dollar minimum capital and surplus requirements that have existed for years in the insurance laws of New Jersey and other states, and will provide the Commissioner with a powerful and highly effective new tool in assuring a marketplace of secure and well capitalized insurers for the life and health insurance consumer.

The proposed new rules will apply to all life and health insurers doing business in New Jersey. Annual compliance with the rules by domiciled insurers is mandated (N.J.A.C. 11:2-39.3). Limited compliance by foreign insurers is also required (N.J.A.C. 11:2-39.12).

Opposition to the proposal is not expected since the insurance industry generally favors laws and regulations that are intended to: (1) identify insurers that are in troubled financial condition; and (2) assure that necessary steps to address weaknesses are taken at the earliest possible time.

Economic Impact

The proposed rules will have a favorable economic impact to the extent that the use of risk-based capital reduces the potential for insolvency of life and health insurers doing business in New Jersey. Although difficult to quantify, the potential savings to insurers and taxpayers alike resulting from reduced involvement of the New Jersey Life and Health Insurance Guaranty Association may be significant.

Cost of insurer compliance with the proposed rules is not expected to be substantial since insurers are already required to process and report, on a regular basis, detailed financial information concerning their operations. However, a fee of $500.00 is required at N.J.A.C. 11:2-39.8 to accompany filing of RBC Plans.

As noted in the proposal Summary above, these proposed new rules implement P.L. 1993, c.235, which is required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. By becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed new rules. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attended costs. Some of these additional costs will be defrayed through the imposition of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

The Department believes that few, if any, insurers subject to the proposed new rules are "small businesses" as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Additionally, the new rules impose no undue burden or adverse economic impact upon insurers which may qualify as "small businesses."

Small companies can expect to incur modest additional administrative expenses, but compliance with the proposed new rules requires only minimal additional reporting and should result in little or no change in the companies' present operations. It is anticipated that the insurers presently maintain, or otherwise provide for, all services which may be required in order to comply with the new rules. All companies should be able to easily absorb these costs. Moreover, these rules include "phase-in" provisions in order to allow insurers time to comply.

Because the cost of compliance with these proposed new rules is minimal, and represents no adverse economic impact upon small businesses, no exceptions for compliance by small insurers have been incorporated into the rules.

Full text of the emergency adopted and concurrently proposed new rules follows:

SUBCHAPTER 39. INCREASE IN CAPITAL AND SURPLUS REQUIREMENTS FOR LIFE AND HEALTH INSURERS

11:2-39.1 Purpose and scope

The purpose of this subchapter is to provide a framework for the establishment of uniform risk-based capital and surplus requirements for all insurers authorized to write life, health and annuity business specified in N.J.S.A. 17B:17-3, 4 and 5, and to implement the provisions of P.L. 1993, c.235 (enacted August 9, 1993), which provide new minimum capital and surplus requirements and authorize the Commissioner to increase these requirements for individual insurers based upon the insurer's business risks.

11:2-39.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Adjusted RBC Report" means an RBC Report which has been adjusted by the Commissioner in accordance with N.J.A.C. 11:2-39.3(d).

"Corrective Order" means an order issued by the Commissioner in accordance with N.J.A.C. 11:2-39.5(b).

"NAIC" means the National Association of Insurance Commissioners.

"NAIC RBC Instructions" means the form of the Life Risk-Based Capital Report and instructions for completing such form adopted by the NAIC, as such form and instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"NAIC RBC Report" means the Life Risk-Based Capital Report prepared pursuant to the NAIC RBC Instructions.

"Negative trend" means a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the NAIC RBC Instructions.

"RBC" means Risk-Based Capital.

"RBC Instructions" means the NAIC RBC Instructions as supplemented by the Commissioner.

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"RBC Level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

1. "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;

2. "Regulatory Action Level RBC" means, with respect to any insurer, the product of 1.5 and its Authorized Control Level RBC;

3. "Authorized Control Level RBC" means, with respect to any insurer, the number determined under the risk-based capital formula in accordance with the RBC Instructions; and

4. "Mandatory Control Level RBC" means, with respect to any insurer, the product of .70 and its Authorized Control Level RBC.

"RBC Plan" means a comprehensive financial plan containing the elements specified at N.J.A.C. 11:2-39.4(b). If the Commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "Revised RBC Plan."

"RBC Report" means the NAIC RBC Report as supplemented pursuant to the RBC Instructions.

"Required capital" is zero for any mutual insurer, and for any stock insurer means:

1. $1,000,000 for either or both kinds of business specified in N.J.S.A. 17B:17-3 and 5;

2. $700,000 for the kind of business specified in N.J.S.A. 17B:17-4; and

3. $1,530,000 for all three kinds of business specified in N.J.S.A. 17B:17-3, 4 and 5.

"Required surplus" means, for any insurer, such amount of statutory surplus as would cause the insurer's total adjusted capital to equal its Mandatory Control Level RBC, but in no event less than:

1. For either or both kinds of business specified in N.J.S.A. 17B:17-3 and 5, $4,000,000;

2. For the kind of business specified in N.J.S.A. 17B:17-4, $2,800,000 for a stock insurer or $3,000,000 for a mutual insurer; and

3. For all three kinds of business specified in N.J.S.A. 17B:17-3, 4 and 5, $6,120,000 for a stock insurer or $6,300,000 for a mutual insurer.

"Total adjusted capital" means an insurer's statutory capital and surplus increased or decreased by such other items, if any, as the RBC Instructions may provide.

11:2-39.3 RBC reports

(a) Every domestic insurer authorized to write life insurance, health insurance or annuity business in this State shall, on or before each March 15 (the "filing date"), prepare and submit to the Commissioner an RBC Report as of the preceding December 31. The RBC Report shall be sent or delivered to:

New Jersey Department of Insurance
Financial Examinations, RBC Reports
20 West State Street
CN 325
Trenton, New Jersey 08625

(b) If at any time the Commissioner believes that the financial condition of an insurer authorized to write life insurance, health insurance or annuity business in this State may have materially changed, the Commissioner may request in writing an updated RBC Report from the insurer. In such event, the insurer shall, on or before the 45th day following such request (the "filing date"), prepare and submit to the Commissioner at the address in (a) above an RBC Report as of the last day of the calendar month coincident with or last preceding the date of the request.

(c) Every domestic insurer shall also file its NAIC RBC Report with the NAIC in accordance with the NAIC RBC Instructions. In addition, if the insurer has been notified in writing by the insurance department of any state in which the insurer is authorized to do business, the insurer shall file its NAIC RBC Report with such state by the filing date or, if later, within 15 days from receipt of notice to file.

(d) If an insurer files an RBC Report which in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment.

(e) The calculation of an insurer's required surplus as set forth in an RBC Report filed and accepted by the Commissioner pursuant to (a) or (b) above, or as adjusted by the Commissioner pursuant to (d) above, shall be deemed to be a redetermination of the insurer's minimum statutory capital and surplus requirement pursuant to P.L. 1993, c.235, §4.

1. If an insurer disagrees with the minimum capital and surplus as determined above, it may request a hearing as provided at N.J.A.C. 11:2-39.9.

2. An insurer requesting a hearing shall do so upon filing an RBC Report, or within 20 days of receipt of notice from the Commissioner of an adjustment.

3. Failure to request a hearing shall be deemed to be a waiver of the right to a hearing on the redetermined minimum capital and surplus requirement for the insurer.

11:2-39.4 Company action level event

(a) "Company action level event" means any of the following events:

1. The filing of an RBC Report by an insurer which indicates that:

i. The insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC; or

ii. The insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 2.5 and has a negative trend;

2. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in (a)1i or ii above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9; or

3. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1i or ii above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a company action level event, a domestic insurer shall within 45 days prepare and submit to the Commissioner an RBC Plan which shall:

1. Identify the conditions in the insurer which contribute to the company action level event;

2. Set forth corrective actions which the insurer intends to take that are reasonably expected to result in the elimination of the company action level event;

3. Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and/or surplus. (The projections of both new and renewal business shall include separate projections for each major line of business and separately identify each significant income, expense and benefit component);

4. Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the insurer's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance in each case, if any.

(c) Within 60 days after the submission by a domestic insurer of an RBC Plan or a Revised RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether such Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines that the Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the Plan satisfactory, in the judgment of the Commissioner. The Commissioner may, at his or her discretion, subject to the insurer's right to a hearing under N.J.A.C. 11:2-39.9, specify in the notification that the notification constitutes a regulatory action level event. Upon notification from the Commissioner, the insurer shall

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prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner:

1. Within 45 days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under N.J.A.C. 11:2-39.9, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Every domestic insurer that flies an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

1. Such state has a confidentiality provision substantially similar to N.J.A.C. 11:2-39.10(a); and

2. The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

i. Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

ii. The date on which the RBC Plan or Revised RBC Plan is filed under (b) or (c) above.

11:2-39.5 Regulatory action level event

(a) "Regulatory action level event" means, with respect to any insurer, any of the following events:

1. The filing of an RBC Report by an insurer which indicates that the sum of its capital and statutory surplus is at least 110 percent but less than 125 percent of the sum of its required capital and required surplus.

2. The filing of an RBC Report by an insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

3. The notification by the Commissioner to an insurer of an Adjusted RBC Report that indicates the event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9;

4. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 or 2 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

5. The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

6. The failure of the insurer to comply with the filing deadlines set forth at N.J.A.C. 11:2-39.4(b) and (c);

7. Notification by the Commissioner to the insurer that:

i. An RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

ii. Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under N.J.A.C. 11:2-39.9;

8. If the insurer, under N.J.A.C. 11:2-39.9, challenges a determination by the Commissioner pursuant to (a)7 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

9. Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event in accordance with its RBC Plan or Revised RBC Plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under N.J.A.C. 11:2-39.9; or

10. If the insurer, under N.J.A.C. 11:2-39.9, challenges a determination by the Commissioner pursuant to (a)9 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the challenge (unless the failure of the insurer to adhere to its RBC Plan or Revised RBC Plan has no substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event with respect to the insurer).

(b) In the event of a regulatory action level event, the Commissioner shall for a domestic insurer, and may for a foreign insurer pursuant to N.J.A.C. 11:2-39.12:

1. Require the insurer to prepare and, within 45 days, submit an RBC Plan or, if applicable, a Revised RBC Plan;

2. Perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

3. Subsequent to the examination or analysis, issue a Corrective Order specifying such corrective actions as the Commissioner shall determine are required.

(c) In determining corrective actions, the Commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities and operations of the insurer including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions.

(d) The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine and analyze the assets, liabilities and operations of the insurer and formulate the Corrective Order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other affiliated or controlling party as directed by the Commissioner.

11:2-39.6 Authorized control level event

(a) "Authorized control level event" means any of the following events:

1. The filing of an RBC Report by an insurer which indicates that the sum of its capital and statutory surplus equals or exceeds by less than 10 percent the sum of its required capital and required surplus.

2. The filing of an RBC Report by an insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

3. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9;

4. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates an event in (a)1 or 2 above, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

5. The failure of the insurer to comply with the filing deadline set forth at N.J.A.C. 11:2-39.5(b)1, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured such failure within 10 days after the deadline.

6. The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a corrective order, provided the insurer has not challenged the corrective order under N.J.A.C. 11:2-39.9; or

7. If the insurer has challenged a corrective order under N.J.A.C. 11:2-39.9 and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(b) In the event of an authorized control level event with respect to an insurer, the Commissioner shall:

1. Take such actions as are required under N.J.A.C. 11:2-39.5 regarding an insurer with respect to which a regulatory action level event has occurred; or

2. If the Commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control pursuant to N.J.S.A. 17B:32-31 et seq. In the event the Commissioner takes such actions, the authorized control level

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event shall be deemed sufficient grounds for the Commissioner to take action under the said Act, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in the said Act.

11:2-39.7 Mandatory control level event

(a) "Mandatory control level event" means any of the following events:

1. The filing of an RBC Report which indicates that the sum of the insurer's capital and statutory surplus is less than the sum of its required capital and required surplus;

2. The filing of an RBC Report which indicates that the insurer's total adjusted capital is less than its Mandatory Control Level RBC;

3. Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9; or

4. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 or 2 above, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a mandatory control level event as set forth in (a)2, 3 or 4 above, the Commissioner shall take actions necessary to cause a domestic insurer to be placed under regulatory control pursuant to N.J.S.A. 17B:32-31 et seq. In that event, the mandatory control level event shall be deemed sufficient grounds for the Commissioner to take action under the said Act, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in the said Act. In the event the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under provisions of the said Act. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the mandatory control level event if he or she finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period. In the event of a mandatory control level event as set forth in (a)1 above, the Commissioner may take such action as provided in this subsection.

11:2-39.8 Filings of RBC Plans

A filing of an RBC Plan pursuant to N.J.A.C. 11:2-39.4(b), 5(b) or 15(a)2 shall be accompanied by a nonrefundable filing fee of $500.00 and shall be sent or delivered to:

New Jersey Department of Insurance
Financial Examinations, Capital and Surplus Waivers
20 West State Street
CN 325
Trenton, New Jersey 08625

11:2-39.9 Hearings

(a) An insurer shall have the right to a departmental hearing, on a record, at which the insurer may challenge any determination or action by the Commissioner.

(b) The insurer shall notify the Commissioner of its request for a hearing within five days upon:

1. Notification to the insurer by the Commissioner of an Adjusted RBC Report; or

2. Notification to the insurer by the Commissioner that:

i. The insurer's RBC Plan or Revised RBC Plan is unsatisfactory; and

ii. Such notification constitutes a Regulatory Action Level Event with respect to such insurer; or

3. Notification to any insurer by the Commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event or Regulatory Action Level Event with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

4. Notification to the insurer by the Commissioner of a Corrective Order with respect to the insurer; or

5. Increased requirements pursuant to P.L. 1993, c.235, §4.

(c) Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 20 days after the date of the Commissioner's notice to the insurer granting the hearing.

(d) All matters pertaining to a hearing or to an increase of capital or surplus pursuant to these rules shall be confidential and not subject to subpoena or public inspection, except to the extent that the Commissioner finds release of information necessary to protect the public.

(e) Failure to request a hearing upon filing of an RBC Report or failure to request a hearing within 20 days of notice of an Adjusted RBC Report shall be deemed a waiver of an insurer's right to a hearing pursuant to P.L. 1993, c.235, §4.

11:2-39.10 Confidentiality and prohibition on announcements

(a) All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or reports of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the Commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which are filed with the Commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the Commissioner. This information shall not be made public and/or be subject to subpoena, other than by the Commissioner and then only for the purpose of enforcement actions taken by the Commissioner pursuant to this subchapter or any other provision of the insurance laws of this State.

(b) The comparison of an insurer's total adjusted capital to any of its RBC Levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this subchapter, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurer's RBC Levels is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

11:2-39.11 Supplemental provisions

The provisions of this subchapter are supplemental to any other provisions of the laws of this State, and shall not preclude a limit any other powers or duties of the Commissioner under such laws including, but not limited to, N.J.S.A. 17B:32-31 et seq. and N.J.A.C. 11:2-27.

11:2-39.12 Foreign insurers

(a) Any foreign insurer shall, upon the written request of the Commissioner, submit to the Commissioner an RBC Report as of the end of the calendar year just ended the later of the filing date or within 15 days after the request is received by the foreign insurer.

(b) Any foreign insurer admitted to transact business in this State shall promptly submit to the Commissioner a copy of any RBC Plan or Revised RBC Plan that is filed with the insurance commissioner of any other state.

(c) In the event of a company action level event or regulatory action level event with respect to any foreign insurer, if the insurance

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commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in a manner substantially similar to that specified under N.J.A.C. 11:2-39.4, the Commissioner may require the foreign insurer to file an RBC Plan with the Commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new business in this State.

(d) In the event of an authorized control level event or a mandatory control level event with respect to any foreign insurer, if no domicilary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the Superior Court pursuant to N.J.S.A. 17B:32-31 et seq. with respect to the liquidation of property of foreign insurers found in this State, and the occurrence of the Authorized Control Level Event or Mandatory Control Level Event shall be considered adequate grounds for the application.

11:2-39.13 Severability clause

If any provision of this subchapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this subchapter which can be given effect without the invalid provision or application, and to that end the provisions of this subchapter are severable.

11:2-39.14 Notices

All notices by the Commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail to the insurer's mailing address as provided pursuant to N.J.A.C. 11:1-25 or, in the case of any other transmission, shall be effective upon the insurer's receipt of such notice.

11:2-39.15 Phase-in provision

(a) An insurer subject to this subchapter may request a temporary waiver of the minimum capital and surplus requirements set forth in P.L. 1993, c.235 as follows:

1. The insurer must make application in writing to the Commissioner by October 15, 1993. The waiver request shall be forwarded to:

New Jersey Department of Insurance
Financial Examinations, Capital and Surplus Waivers
20 West State Street
CN 325
Trenton, New Jersey 08625

2. Filing the waiver request shall constitute a regulatory action level event. The insurer shall prepare and file an RBC Plan with the Commissioner at the same address as set forth above, but the time for filing the RBC Plan shall be extended to 120 days. After such review, examination and analysis as is deemed necessary, the Commissioner shall issue a corrective order which may include an appropriate limited waiver of the minimum capital and surplus requirements. In no event shall the corrective order temporarily waive the applicable capital and surplus requirements for a period of more than five years.

3. If the insurer is responding to the corrective order in a manner satisfactory to the Commissioner, then the filing of an RBC Report shall not constitute an authorized control level event or a mandatory control level event.

(b) For RBC Reports required to be filed with respect to 1993, the following requirements shall apply in lieu of the provisions of N.J.A.C. 11:2-39.5, 39.6 and 39.7:

1. In the event of a regulatory action level event under N.J.A.C. 11:2-39.5(a)1, 2 or 3, the Commissioner shall take the actions required under N.J.A.C. 11:2-39.4.

2. In the event of a regulatory action level event under N.J.A.C. 11:2-39.5(a)4, 5, 6, 7 or 9 or an authorized control level event, the Commissioner shall take the actions required under N.J.A.C. 11:2-39.5 with respect to the insurer.

3. In the event of a mandatory control level event with respect to an insurer, the Commissioner shall take the actions required under N.J.A.C. 11:2-39.6 with respect to the insurer.

(c)Until August 16, 1996, all insurers shall be deemed to have applied for, and been granted, a waiver from the requirement of P.L. 1993, c.235 §2 to maintain their minimum capital and surplus in cash and short term assets. This waiver shall not be construed to prevent the Commissioner from taking any other action authorized by law with regard to an insurer's financial condition including, but not limited to, action pursuant to N.J.S.A. 17B:32-31 et seq.; P.L. 1993, c.245; and N.J.A.C. 11:2-27.

(a)

DIVISION OF ACTUARIAL SERVICES

Life, Health and Annuity Reinsurance Agreements

Adopted Emergency Rules and Concurrent Proposed Rules: N.J.A.C. 11:2-40

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.453.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6, 17:23-1 et seq., 17:44A-24, 17:45-1 et seq., 17B:18-62 et seq., 17B:21-1 et seq., and P.L. 1993, c.243.

Concurrent Proposal Number: PRN 1993-516.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:

Verice M. Mason
Assistant Commissioner
Division of Legislative and Regulatory Affairs
Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The agency emergency adoption and concurrent proposal follows:

Summary

Reinsurance is intended to transfer risk liabilities from one insurer ("ceding insurer") to another ("reinsurer"), in order to reduce or limit the threat of unexpected adverse experience to the ceding insurer's earnings and surplus. The Department of Insurance ("Department") recognizes that life, health and annuity insurers regularly transfer risk through reinsurance agreements, many of which produce legitimate increases in the surplus of the ceding insurer ("surplus relief").

The Department also is aware of reinsurance agreements that purport to transfer significant liabilities, producing apparent surplus relief, but that, in fact, produce little or no actual transfer of risk. Agreements of this type may result in a ceding insurer failing to maintain adequate reserve liabilities or establishing unrealizable assets, thereby distorting financial statements and masking what may be a hazardous financial condition. Moreover, the terms of such agreements may violate specific provisions of State law, such as N.J.S.A. 17B:19-8, 17B:21-1 et seq., 17B:30-5 and 17B:18-64.

The Department's intent in proposing these new rules is to enhance the protection of the insured public by curtailing the improper and unsound distortion of ceding insurers' financial statements, based upon reinsurance agreements which do not provide a transfer of actual risk sufficient to justify the claimed surplus relief. Under these proposed new rules, a ceding insurer entering into questionable reinsurance agreements

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will be prohibited from reducing reserve liabilities or establishing assets for reinsurance, except with the prior approval of the Department based on a review of the agreement and its financial effects. These proposed new rules are in accordance with the National Association of Insurance Commissioners ("NAIC") Model Regulation on life and health reinsurance agreements, and are part of the Department's package of legislation and rules required for NAIC accreditation.

These new rules do not apply to assumption reinsurance agreements, nor to reinsurance agreements entered into by health service corporations. In the future, the Department intends to propose rules specifically relating to these excepted agreements.

N.J.A.C. 11:2-40.1 sets forth the purpose and scope of these proposed new rules. The purpose of the rules is to provide standards for reinsurance agreements. Generally, all insurers authorized to transact the business of life and/or health insurance in this State, all property and casualty insurers transacting accident and health insurance, and all reinsurance agreements, current and new, must meet the standards of these proposed new rules, in order for the reinsurance agreement to be one which the Department recognizes for the purpose of allowing credit for reinsurance.

N.J.A.C. 11:2-40.2 sets forth definitions of words and terms.

N.J.A.C. 11:2-40.3 sets forth certain general contingencies which must be met prior to the reduction of liabilities or establishment of assets by the ceding insurer.

N.J.A.C. 11:2-40.4 sets forth the reinsurance agreement provisions or resultant conditions which are unacceptable for purposes of obtaining credit for reinsurance.

N.J.A.C. 11:2-40.5 sets forth certain limited exceptions which apply to both current and existing agreements and credits taken on financial statements. These exceptions provide for a phase-in period for meeting the requirements of these proposed new rules.

N.J.A.C. 11:2-40.6 sets forth certain standards to be applied to reinsurance agreements in addition to those contained in N.J.A.C. 11:2-40.4.

N.J.A.C. 11:2-40.7 sets forth penalty provisions for failure to comply with the proposed new rules.

N.J.A.C. 11:2-40.8 sets forth severability standards.

Social Impact

The Department does not anticipate any significant or recognizable social impact for insureds, although the practical effect will be more accurate financial statements; hence greater security for policyholders. It may be, however, that by reducing the number of reinsurance agreements acceptable for taking reserve credits, insurers may curtail writing certain types of policies or risks exceeding their retention limits. The Department does not foresee any discernible shrinkage in either the life or health insurance direct writers markets because acceptable reinsurance agreements are available. However, the Department does foresee a possible upward creeping of direct premiums based on higher reinsurance premiums associated with real transfers of risk. It is the Department's position that the benefits of added security for policyholders and more accurate financial statements (which may allow early response to troubled insurers) outweigh additional premium costs which may be incurred.

Economic Impact

Insurers writing direct life and/or health insurance premiums may encounter some increases in reinsurance premium as actual risks are reevaluated, but the Department does not expect that these increases will be substantial.

Some ceding insurers may have to increase their reserves if it is determined that they have improperly reduced liabilities or created assets based on unacceptable reinsurance agreements. The Department does not anticipate that many insurers will be impacted to a significant degree, but does expect that some insurers may be impacted to such a degree that they may cease writing certain of their policies for a period of time.

Moreover, as noted in the proposal Summary above, these rules are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these new rules. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the imposition of appropriate fees under simultaneously proposed rules to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

These proposed new rules may apply to "small businesses" as that term is defined at N.J.S.A. 52:14B-16 et seq., specifically to domestic insurers authorized to transact life and health insurance and annuities business in this State, and to all reinsurers authorized to effect life, accident, health and annuity reinsurance agreements. To the extent that these rules will apply to these small business insurers and reinsurers, the rules' requirements will impose a greater economic burden on them in that they will be required to devote proportionately more staff and financial resources to comply with the rules' requirements, and will be required to incur any costs involved with complying with the rules' requirements.

Under these rules, insurers will be required to file reinsurance agreements with the Department to ensure that such agreements satisfy the requirements of N.J.A.C. 11:2-40.4 in order to receive credit for insurance ceded, which will necessitate utilizing the services of lawyers, certified public accountants and actuaries.

Nevertheless, these new rules impose no new requirements based on insurer size, and any additional costs that will be incurred by insurers and reinsurers in complying with these rules will be minimal. The new rules generally do not mandate any additional reporting or recordkeeping requirements, with the exception that insurers file copies of their reinsurance agreements with the Department. However, the Department does not believe that this requirement is unduly burdensome in that the copies required to be filed are of existing documents, many of which insurers currently file with the Department pursuant to N.J.S.A. 17B:18-64.

The Department emphasizes that the primary purpose of these rules is to establish standards for reinsurance agreements under which ceding insurers may receive credit pursuant to such agreements. The Department additionally notes that the rules provide a "phase-in" period ending December 31, 1995 with respect to existing reinsurance agreements that will enable insurers to confirm their existing agreements to the requirements established under these rules.

Additionally, as stated in the proposal Summary, these new rules are based on an NAIC Model and are required for NAIC accreditation. The NAIC Model provides no different compliance requirements based on insurer size. Moreover, the purpose of these rules is to ensure that the credit for reinsurance reported on the annual statement, required to be filed by insurers is, in fact, justified by the term of the reinsurance agreement in that the agreement provides for an actual transfer of risk from the ceding insurer to the assuming insurer. Further, to ensure consistency and uniformity in the data filed by insurers subject to these rules, and to ensure that the financial condition of all insurers is accurately reported, the rules provide no different compliance requirements based on insurer size.

Full text of the proposed new rules follows:

SUBCHAPTER 40. LIFE, HEALTH AND ANNUITY REINSURANCE AGREEMENTS

11:2-40.1 Purpose and scope

(a) The purpose of this subchapter is to provide standards for reinsurance agreements pursuant to which a ceding insurer may reduce a liability or establish an asset on any financial statements filed with the Department.

(b) This subchapter shall apply to the following:

1. All domestic insurers authorized to transact life insurance, accident and health insurance or annuity business in this State;

2. All foreign and alien insurers authorized to transact life insurance, accident and health insurance or annuity business in this State which otherwise are not subject to rules in their state of domicile that are substantially similar to those contained herein;

3. All property and casualty insurers authorized to transact accident and health insurance;

4. All reinsurers authorized to effect life, accident and health or annuity reinsurance agreements in this State; and

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5. All reinsurance agreements entered into by an entity subject to this subchapter, except as N.J.A.C. 11:2-40.5 may apply.

(c) This subchapter shall not apply with respect to assumption reinsurance agreements. N.J.A.C. 11:2-40.4(a)1, 4, 6 and 7 shall not apply to nonproportional reinsurance. N.J.A.C. 11:2-40.4(a)4, 6 and 7 shall not apply to term reinsurance.

11:2-40.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Actuary" means a Member of the American Academy of Actuaries or a Fellow of the Society of Actuaries or a Fellow of the Casualty Actuarial Society who is qualified by training and experience, pursuant to the standards promulgated by the Actuarial Standards Board, to provide the opinions required in this subchapter.

"Assumption reinsurance" means reinsurance whereby the reinsurer assumes from the ceding insurer all risks, obligations, duties and rights arising under a policy; following assumption, a policy is treated by all persons as if the reinsurer were the insurer which had issued the policy.

"Authorized" means that an insurer has a certificate of authority issued by the Commissioner to act as an insurer in this State pursuant to Title 17 or 17B of the New Jersey Statutes.

"Catastrophe reinsurance" means reinsurance of the risk that the aggregate number or dollar amount of claims incurred under a set of policies as a result of a single event or occurrence, such as an accident or a storm, will exceed a defined threshold number or amount.

"Ceding insurer" means an insurer which procures indemnification for itself from another insurer with respect to all or part of an insurance risk associated with one or more policies issued by the former insurer, should losses be sustained.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Domestic" means an entity formed under the laws of this State.

"Insurer" means any person or entity transacting the business of life, accident or health insurance, or annuities.

"LTC" means long-term care insurance.

"Policy" means any life insurance, health insurance or annuity policy or contract, as defined pursuant to N.J.S.A. 17B:17-3, 4 and 5, which is not reinsurance.

"Reinsurance" means a contractual arrangement whereby an insurer, for some consideration, agrees to indemnify a ceding insurer for all or part of a loss which the ceding insurer may incur under one or more policies that the ceding insurer has or will issue. This term is intended to include facultative reinsurance, automatic reinsurance agreements, reinsurance agreements of pools and associations, and such other similar reinsurance arrangements by whatever name or device.

"Reinsurance credit" means the amount of a liability reduction or the asset established as permitted by this subchapter.

"Reinsurer" means an insurer which agrees to provide reinsurance.

"Renewable term reinsurance" means term reinsurance which is renewable, automatically or at the option of the ceding insurer, for successive terms at rates not exceeding those guaranteed in the reinsurance agreement.

"Significant risk" means an element of risk associated with a policy such that the actual experience of an insurer related to such element will have a direct and material effect on the profit or loss realized by the insurer as a consequence of having issued or assumed such policy.

"Stop-loss reinsurance" means reinsurance of the risk that the aggregate number or dollar amount of claims incurred under a set of policies during a specified period will exceed a defined threshold number or amount.

"Term reinsurance" means reinsurance of the risk that a mortality or morbidity claim on an insured life will be incurred during a specified term, such as one year.

11:2-40.3 Reinsurance agreements

(a) No ceding insurer subject to this subchapter shall enter into any new reinsurance agreement, nor amend any existing reinsurance agreement so as to increase its reinsurance credit, which shall reduce any liability or establish any asset in any financial statement filed with the Department except pursuant to the following requirements:

1. The reinsurance agreement or amendment shall be filed with the Commissioner no later than 30 days after its execution. In addition, no domestic insurer shall enter into any reinsurance agreement involving a substantial transfer of risk without the prior approval of the Commissioner. For purposes of this subsection, a transfer of risk associated with a reinsurance agreement is considered to be substantial if a material number or percentage of policies are affected by the agreement, or if there is a material change in the reserve liabilities on the policies affected by the agreement. Such agreements shall be submitted to:

Vaulation and Statement Bureau
Life and Health Actuarial Services
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625-0325

2. This filing shall include a written opinion of an actuary representing the reinsurer which describes the ceding insurer's significant risks under the policies reinsured and specifies the extent (if any) to which these significant risks are transferred to the reinsurer.

(b) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the last day of the period covered by the financial statement, filed with the Commissioner pursuant to (a) above and meets the following standards:

1. In the case of a letter of intent, the letter of intent shall stipulate that the reinsurance agreement is subject to approval by the Commissioner, and that no reserve credits shall be taken by the insurer until the Commissioner has approved the agreement.

2. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, and before the filing of the first financial statement in which a credit is to be taken, in order for credit to be granted for the reinsurance ceded.

3. The reinsurance agreement or amendment shall stipulate that coverage thereunder shall terminate if it is not approved by the Commissioner and that, in any financial statement filed before the Commissioner has approved it, the ceding insurer shall take no reinsurance credit therefor, other than for any net cash refund available in the event that the agreement is not approved.

4. The reinsurance agreement shall stipulate that the written agreement, including any written amendments thereto, as filed with the Commissioner constitutes the entire agreement between the parties with respect to the risks being reinsured thereunder. The reinsurance agreement shall further stipulate that to the extent the original agreement required prior approval by the Commissioner, any change or modification of its terms shall be null and void unless made by written amendment signed by both parties and filed with the Commissioner for approval along with any necessary revisions to the actuarial opinion required by (a)2 above. There shall be no additional terms or conditions, either written or oral, and the parties to the reinsurance agreement shall not enter into any understandings or supplemental agreements with respect to the reinsurance, other than those set forth in the written agreement filed with the Commissioner.

5. The reinsurer shall not require, and the ceding insurer shall not make, any representations or warranties about the future experience under the policies being reinsured, nor any other representations or warranties which are not reasonably related to the policies being reinsured.

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11:2-40.4 Agreements or conditions precluding reduction of liability or inclusion as an asset

(a) Except as N.J.A.C. 11:2-40.5 applies, no insurer shall reduce any liability or establish any asset in any financial statement filed with the Department for any reinsurance ceded if by the terms of the reinsurance agreement, any of the following conditions exist, in substance or effect:

1. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured unless an adequate liability is established by the ceding insurer for the present value of the shortfall by taking into consideration assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the ceding insurer at the time the business is reinsured;

2. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for non-payment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets;

3. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negatives experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

4. The ceding insurer is required, at specific points in time scheduled in the agreement, to terminate or automatically recapture all or part of the reinsurance ceded;

5. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company;

6. The treaty does not transfer all of the significant risk inherent in the business being reinsured. Exhibit 1 entitled "Significant Risks" appearing in the Appendix to this subchapter identifies the risks considered to be significant for the various products or types of business set forth in the table. For products not specifically included, the risks determined to be significant shall be consistent with this table;

7. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in (a)8 below) either transfer the underlying assets to the reinsurer, maintain such assets in a separate trust or escrow account, or otherwise establish a mechanism by contractual arrangement satisfactory to the Commissioner whereby the underlying assets are legally segregated;

8. Notwithstanding the requirements of (a)7 above, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of such assets: Health Insurance—LTC/LTD; Traditional Non-Par Permanent; Traditional Par Permanent; Adjustable Premium Permanent; Indeterminate Premium Permanent; and Universal Life Fixed Premium (no dump-in premiums allowed). The formula for determining the reserve interest rate adjustment should reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reflected in the financial statement. The formula set forth as Exhibit 2 in the Appendix to this subchapter is an example of an acceptable formula;

9. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date;

10. The ceding insurer is required to make representations or warranties which are not reasonably related to the business being reinsured;

11. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured;

12. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(b) Notwithstanding (a) above, in financial statements filed with the Department a ceding insurer subject to this subchapter may, with the prior approval of the Commissioner, take such reinsurance credit as the Commissioner may deem consistent with the fair presentation of the insurer's financial condition under statutory accounting principles (as permitted or prescribed by Title 17B of the New Jersey revised statutes and rules and regulations promulgated thereunder), including actuarial interpretations and standards adopted by the Department.

11:2-40.5 Exceptions to agreements or conditions precluding reduction of liability or inclusion as an asset

(a) Agreements entered into on or after August 16, 1993 which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days from their date of execution.

(b) Any increase in surplus net of Federal income tax resulting from arrangements described in (a) above shall be identified separately on the insurer's financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance Ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

(c) Insurers subject to this subchapter shall reduce to zero by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to August 16, 1993 which, under the provisions of this subchapter would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding August 16, 1993.

11:2-40.6 Additional standards

(a) Each reinsurance agreement filed with the Department shall be accompanied by documentation detailing the financial impact of the agreement. This documentation shall include information as to reserves transferred under the agreement and details as to payment and expense charges to and from each party to the agreement. The ceding insurer's actuary signing the financial statement actuarial opinion with respect to the valuation of reserves shall consider this subchapter and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Department. The actuary shall maintain adequate documentation and be prepared upon request by the Department to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this subchapter.

(b) Compliance with N.J.A.C. 11:2-40.4 shall not abrogate the requirement that reserve credits shall be based upon actual liability assumed by a reinsurer to reimburse a ceding insurer for benefits that the ceding insurer is obligated to pay under its direct policies

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and that gave rise to a required statutory reserve amount. An agreement meeting the technical requirements of N.J.A.C. 11:2-40.4, but failing to comply with the objective of this rule, shall not provide a basis for the taking of reserve credits by a ceding insurer.

(c) The ceding insurer shall maintain data used to determine reinsurance credits at its place of business for review by the Department upon request. Such data and documentation shall demonstrate compliance by the ceding insurer with this subchapter, and shall include, but not be limited to:

1. A comparison of the renewal expense allowances with the ceding insurer's anticipated expenses; and

2. A comparison of the guaranteed reserve adjustment interest rates to the maximum allowable statutory valuation rates in accordance with N.J.S.A. 17B:19-8.

11:2-40.7 Penalties

Failure to comply with the terms of this subchapter may result in the denial of any credit taken for the reinsurance agreement, as well as the assessment of any and all penalties available pursuant to law. These penalties may be assessed against any and all parties to a reinsurance agreement that fails to comply with the terms of this subchapter.

11:2-40.8 Severability

If any provision of this subchapter or the application thereof to any person or circumstance is held to be invalid for any reason, the remainder of the subchapter and the application of such provision to other persons or circumstances shall not be affected thereby.

APPENDIX

EXHIBIT 1

Significant Risks

Products/Types of Business	Risk Categories** a	b	c	d	e	f
Health Insurance—other than LTC/LTD*	+	O	+	O	O	O
Health Insurance—LTC/LTD*	+	O	+	+	+	O
Immediate Annuities	O	+	O	+	+	O
Single Premium Deferred Annuities	O	O	+	+	+	+
Flexible Premium Deferred Annuities	O	O	+	+	+	+
Guaranteed Interest Contracts	O	O	O	+	+	+
Other Annuity Deposit Business	O	O	+	+	+	+
Single Premium Whole Life	O	+	+	+	+	+
Traditional Non-Par Permanent	O	+	+	+	+	+
Traditional Non-Par Term	O	+	+	O	O	O
Traditional Par Permanent	O	+	+	+	+	+
Traditional Par Term	O	+	+	O	O	O
Adjustable Premium Permanent	O	+	+	+	+	+
Indeterminate Premium Permanent	O	+	+	+	+	+
Universal Life Flexible Premium	O	+	+	+	+	+
Universal Life Fixed Premium	O	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	O	+	+	+	+	+

+ = Significant/O = Insignificant

*LTC = Long Term Care Insurance
LTD = Long Term Disability Insurance

**Risk categories

a. Morbidity

b. Mortality

c. Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

d. Credit Quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

e. Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

f. Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

EXHIBIT 2

Formula for Determining Reserve
Interest Rate Adjustment

$$\text{Rate} = \frac{2\,(I + CG)}{X + Y - I - CG}$$

Where: I is the net investment income

CG is capital gains less capital losses

X is the current year cash and invested assets plus investment income due and accrued less borrowed money

Y is the same as X but for the prior year

All data is as reported in the Annual Statement.

(a)

DIVISION OF LICENSING ENFORCEMENT AND CONSUMER PROTECTION

Managing General Agents

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:17-6

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.454.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e) and P.L. 1993, c.237.

Concurrent Proposal Number: PRN 1993-517.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:
Verice M. Mason, Assistant Commissioner
Legislative and Regulatory Affairs
Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The emergency adoption and concurrent reproposal follows:

Summary

The Department of Insurance ("Department") is proposing a series of new rules as part of the National Association of Insurance Commissioner's ("NAIC") Financial Regulation and Accreditation Program. The NAIC Accreditation program provides specific laws, regulations, practices and procedures that the NAIC believes all states need to have

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in place to adequately monitor the financial condition of insurers. In order to receive NAIC Accreditation a state's compliance is reviewed and evaluated by an independent audit team.

If New Jersey is not accredited by January 1, 1994, any state which is accredited will not accept examinations of New Jersey domestic insurers conducted by this Department. The number of New Jersey domestics that would be impacted by failure to obtain NAIC accreditation is: 27 property/casualty insurers and 12 life or health insurers.

In an effort to obtain NAIC accreditation by January 1, 1994, the Department is adopting and concurrently proposing new rules which regulate managing general agents (MGAs). Managing general agents through their responsibilities such as final underwriting functions and claim settlement authority and the amount of premiums written for an insurer, have the potential to significantly effect the financial solvency of an insurer. These proposed new rules implement P.L. 1993, c.237 to require that managing general agents working for insurers providing coverage for a risk in New Jersey or working for the New Jersey domestic insurer be licensed as a producer. The statute and these rules require an MGA to maintain a surety bond and an errors and omissions policy.

These rules further require insurers to only appoint or use the services of a managing general agent that is qualified to act as an MGA pursuant to this subchapter. Additionally, insurers are required to maintain and make available to the Commissioner upon request a copy of the contract, executed bond and proof of the managing general agent's errors and omissions coverage. Insureres must notify the Department of the appointment or termination of a managing general agent.

In accordance with P.L. 1993, c.237, these rules require all policy and claim files to be the joint property of the insurer and managing general agent. Managing general agents are also required to maintain all required books and records of accounts for a period of five years after termination of the contract.

Proposed N.J.A.C. 11:17-6.1 states the purpose and scope of these rules.

Proposed N.J.A.C. 11:17-6.2 provides the definition for terms used in this subchapter.

Proposed N.J.A.C. 11:17-6.3 provides the requirements for being a managing general agent in this State.

Proposed N.J.A.C. 11:17-6.4 provides requirements for insurers using the services of a managing general agent.

Proposed N.J.A.C. 11:17-6.5 provides the filing requirements for managing general agents and insurers.

Proposed N.J.A.C. 11:17-6.6 provides the claim processing requirements.

Proposed N.J.A.C. 11:17-6.7 states the record maintenance requirements for managing general agents and insurers.

Proposed N.J.A.C. 11:17-6.8 provides the penalties for violating the provisions of this subchapter.

Social Impact

The Department believes that these rules will have a positive social impact especially for insurers. The Department believes these rules are necessary since managing general agents have broad authority to act on an insurer's behalf with respect to certain lines of business including the making of underwriting decisions and, frequently, claim settlement authority. The Department believes that because this is such an important function individuals who act in this capacity need to have special expertise. Therefore, since managing general agents act in the same manner as an insurer, it is essential that the Commissioner have regulatory control over managing general agents.

Economic Impact

The Department believes that no adverse economic impact should be experienced by insurers as a result of the proposed new rules. Insurers will incur a one-time cost of $20.00 per appointment of a managing general agent. This is in accordance with N.J.A.C. 11:17-2.12.

Managing general agents will incur costs relating to the obtaining of a surety bond and errors and omissions coverage in order to comply with the requirements of this subchapter. Persons who wish to become managing general agents who are not already licensed producers will incur costs related to acquiring a producer's license. The Department believes that most of the people who wish to become managing general agents are already licensed producers.

Additionally, the Department does not anticipate any additional costs to managing general agents as a result of the record maintenance requirements since these rules just extend to the producer maintenance requirement records obtained by the producer while acting as a managing general agent. Accordingly, any costs that will be incurred by the managing agents are outweighed by the benefits to be achieved.

Moreover, as noted in the proposal Summary above, these amendments are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework with respect to the financial regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed amendments. The Department anticipates that compliance with and implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the imposition of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

The proposed new rules may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the new rule applies to "small businesses" they will be firms, associations, or corporations who wish to be qualified as a managing general agent in this State. Compliance requirements are as described in the Summary above. The Department believes that these rules are necessary since managing general agents have broad authority to act on an insurer's behalf with respect to certain lines of business including the making of underwriting decisions and frequently claim settlement authority.

The only cost that the Department anticipates small business incurring are those costs for the licensing of producers or qualifying as a managing general agent. In order to effectuate the goals of these rules, no differentiation in requirements based upon business size can be provided in accordance with P.L. 1993, c.237.

Full text of the emergency adopted and concurrent proposed new rules follows:

SUBCHAPTER 6. MANAGING GENERAL AGENTS

11:17-6.1 Purpose and scope

This subchapter implements the provisions of P.L.1993, c.237. This subchapter sets forth the procedures for the regulation of certain persons, firms, associations or corporations who act as managing general agents on behalf of insurers.

11:17-6.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Commissioner" means the Commissiner of the New Jersey Department of Insurance.

"Insurer" means:

1. Any corporation, association, partnership, reciprocol exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq., or N.J.S.A. 17B:17-1 et seq.;

2. Any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

3. Any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. Any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.;

5. Any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

"Managing general agent" or "MGA" means any person, firm, association or corporation who binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office, and acts as an agent for that insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or

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indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following:

1. Authority to adjusts or pays claims in excess of $5,000 per claim or in the aggregate, if the claims will settle for $100,000 or more in a year; or

2. Negotiates reinsurance on behalf of the insurer.

Notwithstanding the above; the following persons shall not be MGAs for the purposes of this subchapter:

1. An employee of the insurer;

2. A United States manager of the United States branch of an alien insurer;

3. An underwriting manager which, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to N.J.S.A. 17:27A-1 et seq., and whose compensation is not solely based on the volume of premiums written;

4. An attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

"Nonresident" means a person who neither resides in New Jersey nor maintains an office in New Jersey where insurance business is transacted.

"Producer" means a person licensed in accordance with N.J.S.A. 17:22A-1 et seq. and N.J.A.C. 11:3-17.

"Resident" (of New Jersey) means a person who either resides in New Jersey or maintains an office in New Jersey where insurance business is transacted.

11:17-6.3 Requirements for MGA

(a) No person, firm, association or corporation shall act in the capacity of a managing general agent with respect to risks located in this State for an insurer licensed in this State unless such person is licensed as an insurance producer in this State.

(b) No person, firm, association or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in this State with respect to risks located outside of this State unless such person is licensed as a producer in this State.

(c) All managing general agents shall acquire and maintain a surety bond for the protection of the insurer contracting with the managing general agent. The bond shall be in the amount of $100,000 or 25 percent up to $10,000,000 of the direct premium written by the insurer for the previous calendar year that is attributable to the managing general agent, whichever is greater.

1. The bond amount shall be adjusted accordingly on or before April 1st of each year.

2. The bond shall be executed by an admitted company authorized to transact fidelity and surety business in New Jersey. The bond shall not be written by the insurer or an affiliate of the insurer contracting with the managing general agent.

3. The executed bond shall be submitted to the insurance company contracting with the MGA.

(d) All managing general agents shall acquire and maintain an errors and omissions insurance policy. The policy coverage limits shall be set at $100,000 or 25 percent up to $10,000,000 of the direct premium written by an insurer for the previous calendar year that is attributable to the MGA, whichever is greater.

1. The policy coverage limits shall be adjusted accordingly on or before April 1st of each year.

2. The errors and omissions policy shall be issued by an insurer admitted to do business in New Jersey or an eligible surplus lines insurer. The policy shall not be written by the insurer or an affiliate of the insurer contracting with the MGA.

3. Proof of an errors and omissions insurance policy shall be submitted to the insurance company contracting with the MGA.

(e) The obligations of the MGA to maintain in force a bond and errors and omissions insurance as provided in this section shall continue until Notice of Termination of Managing General Agent Contract is filed with the Department as provided in this subchapter.

11:17-6.4 Insurer requirements

(a) No insurer shall appoint or continue to use the services of any MGA to act for it in this State, either directly or indirectly through sub-agents of the MGA, unless the managing general agent is qualified to act as an MGA in this State pursuant to N.J.A.C. 11:17-6.3.

(b) The insurer shall maintain and make available to the Commissioner upon request a copy of the following:

1. An executed contract between the MGA and the insurer;

2. An executed bond in accordance with N.J.A.C. 11:17-6.3(e); and

3. Proof of the MGA's errors and omissions coverage in accordance with N.J.A.C. 11:17-6.3(d).

(c) Thirty days of entering into, or within 15 days of terminating, a contract with an MGA, the insurer shall provide written notification of the appointment or termination of the MGA to the Commissioner.

1. Notices of appointment of an MGA filed pursuant to N.J.A.C. 11:17-6.5 shall be filed in the form as set forth as Form A in the Appendix to the subchapter and shall include a statement of duties which the MGA is expected to perform on behalf of the insurer, the lines of insurance for which the MGA is to be authorized to act, and any other information the Commissioner may request. Additionally, the insurer shall include a fee in the amount of $20.00.

2. An insurer shall notify the Commissioner of the termination of the MGA relationship by filing a Notice of Termination of Managing General Agent Contract, by certified mail in the form set forth as Form B in the Appendix to this subchapter.

11:17-6.5 Filing requirements

(a) No person, firm, association or corporation shall act as an MGA with respect to risks located in this State for an insurer licensed or domiciled in this State, unless the MGA and the insurer have notified the Commissioner as provided (b) below.

(b) Insurers and MGAs required to notify the Commissioner as provided in (a) above shall file a Notice of Managing General Agent Contract in the form set forth as Form A in the Appendix to this subchapter incorporated herein by reference by completing and jointly executing the form and sending it to the Department at the following address:

Attn: License Processing
New Jersey Department of Insurance
20 West State Street
CN 327
Trenton, NJ 08625

(c) The Commissioner may refuse to file any Notice of Managing General Agent Contract that is incomplete. The Commissioner shall notify the insurer of a determination that the Notice is incomplete, and the actions that must be taken or the items that must be submitted in order to make a complete filing.

11:17-6.6 Claim processing requirements

(a) If the contract between the MGA and the insurer permits the MGA to settle claims on behalf of the insurer the MGA shall comply with the requirements governing the settlement of claims set forth in N.J.S.A. 17:29B-4, 17B:30-13.1 and 17B:30-13.2 as applicable and any regulations promulgated by the Commissioner thereunder. In addition:

1. All claims shall be reported to the company within 30 days of a claim being reported to the MGA, unless otherwise specified with the insurer; and

2. A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

i. Has the potential to exceed $1,000,000 or exceeds the limit set by the insurer, whichever is less;

ii. Involves a coverage dispute;

iii. May exceed the managing general agent's claims settlement authority;

iv. Is open for more than six months; or

v. Is closed by payment of $1,000,000 or an amount set by the insurer, whichever is less.

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APPENDIX
FORM A

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF MANAGING GENERAL AGENT CONTRACT

To: Commissioner of Insurance, State of New Jersey

From:

|___|___|___|___|___|___|___|___| _____

Company Reference No. Name of Company

The following producer gives notice of the establishment of an agency contract between this company and the insurance producer named below:

|___|___|___|___|___|___|

Insurance Producer Reference No. THIS INFORMATION MAY NOT BE OMITTED

_____

PRINT Name of Insurance Producer (Last, First, Middle)

|___|___| |___|___| |___|___|

month day Year

Date of Birth

THIS INFORMATION MAY NOT BE OMMITTED IF AN INDIVIDUAL PRODUCER

as its Managing General Agent in New Jersey commencing |___|___| month |___|___| day |___|___| year for:

Contract Date

all types of insurance for which the company and producer are jointly authorized. The above producer has filed with this company a bond and Errors and Omissions policy in accordance with N.J.A.C. 11:_____

I have determined that the insurance producer named holds a current New Jersey insurance license, authorizing transaction of the kinds of insurance covered by this contract. We understand that the bond and E&O policy must be updated yearly.

_____ |___|___| _____

Authorized Company Signature Date Phone Number

_____ _____

Print Name and Title Office Address

_____

Date

_____ _____

Insurance Producer Signature Date

Attach a $20.00 company check made payable to: STATE TREASURER OF NEW JERSEY

DT630/INABROP/m/1

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FORM B

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF TERMINATION OF MANAGING GENERAL AGENT

To: Commissioner of Insurance, State of New Jersey

From: |__|__|__|__|__|__|__|__| _____
Company Reference No. Name of Company

The undersigned hereby gives notice of the termination of the agency contract between this company and the insurance producer named below:

|__|__|__|__|__|__|__|
Insurance Producer Reference No.

THIS INFORMATION MAY NOT BE OMITTED

_____
PRINT Name of Insurance Producer (Last, First, Middle)

Said contract terminated on |__|__|__|__|__|__|__|__|
month day Year
Termination Date

Reason for Termination: _____

_____

_____

If the reason for termination is agent misconduct, mail an additional copy of this form to: Director of Enforcement, Department of Insurance, CN 325, Trenton, NJ 08625-0325

_____ |__|__|__| _____
Authorized Company Signature Date Phone Number

_____ _____
Print Name and Title Office Address

_____
Date

DT630/INABROP/m/2

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11:17-6.7 Record maintenance

(a) All policy and claim files shall be the joint property of the insurer and MGA. Upon termination of the MGA appointment for this State, all original policy and claim files shall be returned to the insurer. The MGA may retain copies of these files.

(b) All books and records of account shall be maintained by the managing general agent for a period of five years after the termination of the contract.

(c) All records, books and documents required to be maintained by the managing general agent in accordance with the provisions of this subchapter shall, upon his or her request, be produced for examination by the Commissioner or his or her duly authorized representatives.

(d) The books and records required by this subchapter to be maintained may be maintained electronically if the following conditions are met:

1. That all the elements required by this chapter to be maintained are contained in the electronic system;

2. That, upon the request of the Department, the electronically kept records can be reproduced in hardcopy; and

3. That, at least every 30 days, the records maintained electronically are reproduced in hardcopy and maintained on file for a period of five years after the termination of coverage for an insured, or, alternatively, are maintained for said period of five years on an electronic system that is, in the opinion of the Commissioner, unalterable. Such a determination of unalterability shall be made by the Commissioner, in writing, before any electronic system may be used for storage beyond 30 days.

11:17-6.8 Penalties

(a) If the Commissioner finds, after notice and opportunity for a hearing pursuant to the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. as implemented by the uniform rules of Administrative Procedure, N.J.A.C. 1:1, that any person has violated any provisions of P.L. 1993, c.237 or this subchapter, the Commissioner may refuse to issue or renew the insurance producer's license, or may revoke or suspend the insurance producer's license.

(b) In addition, or as an alternative to any other penalty, the Commissioner may:

1. Impose a fine of up to $5,000 for the first violation, and not exceeding $10,000 for each subsequent violation, and in appropriate circumstances order restitution of moneys owed to any person and reimbursement of the costs of investigation and prosecution.

2. Order the MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this act committed by the managing general agent.

(c) If the Commissioner finds that the interests of the public require that immediate action be taken prior to completion of the hearing, the making of a determination and the entry of a final order, he may enter an appropriate order to be effective pending completion of the hearing and entry of a final order. These orders may be entered on ex parte proofs if the proofs indicate that the Commissioner's withholding of any action until completion of a full hearing will be harmful to the public interest. Orders issued pursuant to this subsection shall be subject to an application to vacate upon 10 days' notice, and a preliminary hearing on the ex parte order shall be held in any event within 20 days after it is entered. In the alternative, or in addition, the Commissioner is authorized to institute a proceeding in the Superior Court, to be conducted in a summary manner, for an injunction against specified acts or conduct in aid of the proceedings pending before him, including temporary injunctions and interim restraints.

(a)

DIVISION OF LICENSING ENFORCEMENT AND CONSUMER PROTECTION

Reinsurance Intermediaries

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:17-7

Emergency Adopted New Rules Adopted and Concurrent Proposed New Rules Authorized: August 12, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): August 13, 1993.

Emergency New Rules Filed: August 16, 1993 as R.1993 d.455.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e) and P.L. 1993, c.244 (enacted August 9, 1993).

Concurrent Proposal Number: PRN 1993-518.

Emergency New Rules Effective Date: August 16, 1993.

Emergency New Rules Expiration Date: October 15, 1993.

Submit comments by October 7, 1993 to:

Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
20 West State Street
CN 325
Trenton, New Jersey 08625

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rules become effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The agency emergency adoption and concurrent reproposal follows:

Summary

The Department of Insurance ("Department") is proposing a series of new rules as part of the National Association of Insurance Commissioner's ("NAIC") Financial Regulation and Accreditation Program. The NAIC Accreditation Program provides specific laws, regulations, practices and procedures that the NAIC believes all states need to have in place to adequately monitor the financial condition of insurers. In order to receive NAIC Accreditation, a state's compliance is reviewed and evaluated by an independent audit team.

If New Jersey is not accredited by January 1, 1994, any state which is accredited will not accept examinations of New Jersey domestic insurers conducted by this Department. The number of New Jersey domestics that would be impacted by failure to obtain NAIC accreditation is: 27 property/casualty insurers and 12 life or health insurers.

In an effort to obtain NAIC accreditation by January 1, 1994, the Department is adopting and concurrently proposing new rules which regulate reinsurance intermediaries. Reinsurance intermediaries are persons, firms or corporations who solicit, negotiate or place reinsurance cessions or retrocessions on behalf of a ceding insurer and who may or may not have binding authority for the insurer. These rules provide regulatory procedures to ensure that reinsurance intermediaries meet the requirements of the new statutes, and will enable the Department to monitor their actions. These proposed new rules implement P.L. 1993, c.244 and require that any person who acts as a reinsurance intermediary must be licensed as a producer in this State and authorized by the Department as provided in this subchapter. These rules also require that a reinsurance intermediary-manager post a bond and maintain an errors and omissions policy.

Proposed N.J.A.C. 11:17-7.1 states the purpose and scope of these rules.

Proposed N.J.A.C. 11:17-7.2 provides the definition for terms used in the subchapter.

Proposed N.J.A.C. 11:17-7.3 provides the requirements for being a reinsurance intermediary.

Proposed N.J.A.C. 11:17-7.4 provides filing requirements for being a reinsurance intermediary.

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Proposed N.J.A.C. 11:17-7.5 states insurer requirements.

Proposed N.J.A.C. 11:17-7.6 states the record maintenance requirements for reinsurance intermediaries.

Proposed N.J.A.C. 11:17-7.7 provides the penalties for violating the provisions of this subchapter.

Social Impact

The Department believes that these rules will have a positive social impact especially for insurers. The Department believes that these rules are necessary since reinsurance intermediaries may solicit, negotiate or place reinsurance cessions or retrocessions on behalf of a ceding insurer but may not have binding authority for that insurer. The Department believes that because this is such an important function individuals who act in this capacity need to at least be licensed as a producer.

Economic Impact

The Department believes that no adverse economic impact should be experienced by insurers as a result of the proposed new rule. Insurers will incur a one time cost of $20 per appointment of a managing general agent. This is in accordance with N.J.A.C. 11:17-2.12.

Reinsurance intermediaries-managers will incur costs relating to the obtaining of a surety bond and errors and omissions coverage in order to become authorized pursuant to this subchaper. Persons who wish to become reinsurance intermediaries who are not already licensed producers will incur costs related to acquiring a producer's license. The Department believes that most of the people who wish to become reinsurance intermediaries are already licensed producers. Additionally, the Department does not anticipate any additional costs to reinsurance intermediaries since these rules extend producer records maintenance requirements to those records maintained by the reinsurance intermediary. Accordingly, any costs that will be incurred by the reinsurance intermediary are outweighed by the benefits to be achieved.

Moreover, as noted in the proposal Summary above, these amendments are required for this State to obtain NAIC accreditation. Through implementation of all of the required minimum financial regulatory standards to obtain accreditation, a uniform regulatory framework regulation of insurers will be provided. Further, by becoming "accredited," additional costs to New Jersey domestic insurers for multiple examinations by other jurisdictions may be avoided. This, in turn, should benefit both policyholders and insurers.

The Department will experience an economic impact as a result of implementation of accreditation standards, including these proposed amendments. The Department anticipates that compliance with an implementation of accreditation standards will require additional staff and attendant costs. Some of these additional costs will be defrayed through the imposition of appropriate fees to help cover some of the costs of providing new services required to implement accreditation requirements.

Regulatory Flexibility Analysis

The proposed new rules may apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the new rules apply to "small businesses," they will be firms, associations or corporations who wish to be qualified as reinsurance intermediaries in this State. The requirements imposed are described in the Summary above. The Department believes that these rules are necessary since reinsurance intermediaries may solicit, negotiate or place reinsurance cessions or retrocessions on behalf of a ceding insurer with or without binding authority for the insurer.

The only cost that the Department anticipates small business incurring are those costs for the licensing of persons as a producer in order to qualify as a reinsurance intermediary. In order to effectuate the goals of these rules, no differentiation in requirements based upon business size can be provided, or is authorized by P.L. 1993, c.244.

Full text of the emergency adopted and concurrent proposed new rules follows:

SUBCHAPTER 7. REINSURANCE INTERMEDIARIES

11:17-7.1 Purpose and scope

This subchapter implements the provisions of P.L. 1993, c.244. This subchapter sets forth the procedures for the regulation of certain persons, firms, associations or corporations who act as reinsurance intermediaries and for insurers which transact business through a reinsurance intermediary.

11:17-7.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Controlling person" means a person which directly or indirectly has the power to direct, or cause to be directed, the management, control or activities of the reinsurance intermediary.

"Insurer" means:

1. A corporation, association, partnership, reciprocal, exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to Subtitle 3 of Title 17 of the Revised Statutes or Subtitle 3 of Title 17B of the New Jersey Statutes;

2. A medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

3. A hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. A health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.; and

5. A dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

"Producer" means a person engaged in the business of an insurance agent, insurance broker or insurance consultant pursuant to N.J.S.A. 17:22A-1 et seq.

"Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

"Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, which solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of that insurer.

"Reinsurance intermediary-manager" means a person which has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for that reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term, except that the following persons shall not be considered a reinsurance intermediary-manager, with respect to that reinsurer, for the purposes of this subchapter:

1. An employee of the reinsurer;

2. A United States manager of a United States branch of an alien reinsurer;

3. An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to N.J.S.A. 17:27A-1 et seq.; and whose compensation is not solely based on the volume of premiums written;

4. The manager of a group, association, pool or organization of insurers which engages in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner or other similar regulatory officer of the state in which the manager's principal business office is located;

5. A licensed attorney-at-law who negotiates contracts or provides general financial counsel provided no commission or brokerage fee is provided.

"Reinsurer" means any person which engages in the activity of insuring part or all of an insurance risk from an originating or ceding insurer.

11:17-7.3 Requirements for reinsurance intermediaries

(a) No person shall act as a reinsurance intermediary in this State unless licensed as a producer in this State. The Commissioner may authorize a person to act as a reinsurance intermediary if that person has complied with the requirements of this subchapter.

1. An authorization issued to a firm or association shall authorize all members of the firm or association and any designated employee to act as reinsurance intermediaries under the authorization, and all those persons shall be named in the application and any supplements thereto.

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2. An authorization issued to a corporation shall authorize all of the officers, and any designated employee and directors thereof, to act as reinsurance intermediaries on behalf of the corporation, and all those persons shall be named in the application and any supplements thereto.

(b) Any firm, association or corporation licensed as a producer in this State, wishing to be authorized as a reinsurance intermediary shall submit the following:

1. A properly completed application (see Appendix Form C, incorporated herein by reference) requesting authorization to act as a reinsurance intermediary. The application shall be signed, dated and certified to be correct by a licensed officer of the corporation;

i. Applications submitted by a firm or association shall provide in the application the names and New Jersey insurance producer reference numbers of all members of the firm/association and any designated employees, who are licensed as producers to act as reinsurance intermediaries on behalf of the corporation;

ii. Applications submitted by corporations shall provide in the application the names and New Jersey insurance producer reference numbers of all of the officers and any designated employees and directors thereof, who are licensed as producers to act as reinsurance intermediaries on behalf of the corporation;

2. If the applicant seeking authorization as a reinsurance intermediary is a nonresident, the application shall provide that the applicant, as a condition precedent to receiving or holding such authorization, designate the Commissioner as agent for service of process. The applicant shall also:

i. Provide the Commissioner with the name and address of a resident of this State upon whom notices or orders of the Commissioner or process affecting such nonresident reinsurance intermediaries may be served; and

ii. Within 30 days notify the Commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commissioner;

3. Any documents or statements required to explain responses to questions concerning the applicant's character, fitness or financial responsibility; and

4. A valid check or money order for $20.00 which shall accompany the application.

(c) A reinsurance intermediary-manager shall acquire and maintain a surety bond for the protection of the reinsurer contracting with the reinsurance intermediary-manager. The bond shall be in the amount of $100,000 or 25 percent up to $10,000,000 of the gross amount of direct premium written by the reinsurer for the previous calendar year that is attributable to the reinsurance intermediary-manager, whichever is greater.

1. The bond amount shall be adjusted accordingly on or before April 1st of each year.

2. The bond shall be executed by an admitted company authorized to transact fidelity and surety business in New Jersey. The bond shall not be written by the insurer or an affiliate of the reinsurer contracting with the reinsurance intermediary.

3. Proof of an executed bond shall be submitted by the insurance company contracting with the reinsurance intermediary and manager.

(d) All reinsurance intermediary-managers shall acquire and maintain an errors and omissions insurance policy. The policy coverage limits shall be set at $100,000 or 25 percent up to $10,000,000 of the direct premium written by a reinsurer for the previous calendar year that is attributable to the reinsurance intermediary-manager, whichever is greater.

1. The policy coverage limits shall be adjusted accordingly on or before April 1st of each year.

2. The errors and omissions policy shall be issued by an insurer admitted to do business in New Jersey or an eligible surplus lines insurer.

3. Proof of an errors and omissions insurance policy shall be submitted to the insurance company contracting with the reinsurance intermediary-manager.

11:17-7.4 Filing requirements

(a) No person, firm, association or corporation shall act as a reinsurance intermediary-broker in this State if the reinsurance intermediary-broker maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

1. In this State, unless such reinsurance intermediary-broker is a licensed producer in this State; or

2. In another state, unless such reinsurance intermediary-broker is a licensed producer in this State or another state having a law substantially similar to this law or such reinsurance intermediary-broker is licensed in this State as a nonresident reinsurance intermediary.

(b) No person, firm, association or corporation shall act as a reinsurance intermediary-manager:

1. For a reinsurer domiciled in this State, unless such reinsurance intermediary-manager is a licensed producer in this State;

2. In this State, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this State, unless such reinsurance intermediary-manager is a licensed producer in this State; or

3. In another state for a nondomestic insurer, unless such reinsurance intermediary-manager is a licensed producer in this State or another state having a law substantially similar to this law or such person is licensed in this State as a nonresident reinsurance intermediary.

(c) Reinsurers and reinsurance intermediaries required to notify the Department as provided in (a) above shall file a Notice of Reinsurance Intermediary-Manager in the form set forth as Form A in the Appendix to this subchapter incorporated herein by reference by completing and jointly executing the form and sending the written contract, a valid check or money order for $20.00, and all necessary attachments to the Department at the following address:

Attention: License Processing
New Jersey Department of Insurance
20 West State Street
CN 329
Trenton, New Jersey 08625

11:17-7.5 Insurer requirement

(a) No insurer or reinsurer shall appoint or continue to use the services of a reinsurance intermediary unless the reinsurance intermediary is qualified to act as a reinsurance intermediary in this State pursuant to N.J.A.C. 11:17-7.3 and 7.4.

(b) Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity shall be pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through a reinsurance intermediary-manager, a true copy of the approved contract shall be filed with the Commissioner for approval. The contract shall provide the minimum requirements specified in P.L. 1993, c.244.

(c) Within 15 days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of that termination to the Commissioner. The reinsurer shall notify the Department of termination of the reinsurance intermediary-manager relationship by filing a Notice of Termination of a reinsurance intermediary-manager the form set forth as Form B in the Appendix to this subchapter. Agency appointment shall not terminate until notice of termination has been received by the Commissioner.

(d) The insurer shall maintain and make available to the Commissioner upon request a copy of the following:

1. For a reinsurance intermediary-manager:

i. An executed bond in accordance with N.J.A.C. 11:17-7.3(c); and

ii. Proof of the reinsurance intermediary-manager's errors and omissions coverage in accordance with N.J.A.C. 11:7-7.3(c); and

2. For a reinsurance intermediary-broker:

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i. An executed contract between the reinsurance intermediary-broker and the insurer or reinsurer.

11:7-7.6 Record maintenance

(a) For at least 10 years after the expiration of each contract of reinsurance transacted by the reinsurance intermediary, the reinsurance intermediary shall keep a complete record for each transaction showing:

1. The type of contract, limits, underwriting restrictions, classes or risks and territory;

2. The period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

3. Reporting and settlement requirement of balances;

4. The rate used to compute the reinsurance premium;

5. The names and addresses of assuming reinsurers;

6. The rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary;

7. Related correspondence and memoranda;

8. Proof of placement;

9. Details regarding retrocessions handled by the reinsurance intermediary, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

10. Financial record, including, but not limited to, premium and loss accounts; and

11. When the reinsurance intermediary procures a reinsurance contract on behalf of a ceding licensed insurer.

(b) All records, books and documents required to be maintained by the provisions of this subchapter shall, upon his or her request, be produced for examination by the Commission or his or her duly authorized representatives.

(c) The books and records required by this subchapter to be maintained may be maintained electronically if the following conditions are met:

1. That all the elements required by this subchapter to be maintained are contained in the electronic system;

2. That, upon the request of the Department, the electronically kept records can be reproduced in hardcopy; and

3. That, at least every 30 days, the records maintained electronically are reproduced in hardcopy and maintained on file for a period of five years after the termination of coverage for an insured, or, alternatively, are maintained for said period of five years on an electronic system that is, in the opinion of the Commissioner, unalterable. Such a determination of unalterability shall be made by the Commissioner, in writing, before any electronic system may be used for storage beyond 30 days.

11:17-7.7 Penalties

(a) If the Commissioner finds, after notice and opportunity for a hearing pursuant to the provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq. as implemented by the Uniform Rules of Administrative Procedure, N.J.A.C. 1:1, that any person has violated any provisions of P.L.1993, c.244 or this subchapter, the Commissioner may refuse to issue or renew the insurance producer's license, or may revoke or suspend the insurance producer's license.

(b) In addition, or as an alternative to any other penalty, the Commissioner may:

1. Impose a fine of up to $5,000 for the first violation, and not exceeding $10,000 for each subsequent violation, and in appropriate circumstances other restitution of moneys owed to any person and reimbursement of the costs of investigation and prosecution.

2. Order the reinsurance intermediary to reimburse the insurer, the rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer caused by a violation of this act committed by the reinsurance intermediary.

(c) If the Commissioner finds that the interests of the public require that immediate action be taken prior to completion of the hearing, the making of a determination and the entry of a final order, the Commissioner may enter an appropriate order to be effective pending completion of the hearing and entry of a final order. These orders may be entered on ex parte proofs if the proofs indicate that the Commissioner's withholding of any action until completion of a full hearing will be harmful to the public interest. Orders issued pursuant to this subsection shall be subject to an application to vacate upon 10 days' notice, and a preliminary hearing on the ex parte order shall be held in any event within 20 days after it is entered. In the alternative, or in addition, the Commissioner is authorized to institute a proceeding in the Superior Court, to be conducted in a summary manner, for an injunction against specified acts or conduct in aid of the proceedings pending before him or her, including temporary injunctions and interim restraints.

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APPENDIX
FORM A

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF REINSURANCE INTERMEDIARY-MANAGER

To: Commissioner of Insurance, State of New Jersey

From: |___|___|___|___|___|___|___|___| _____
Company Reference No. Name of Company

The following producer gives notice of the establishment of an agency contract between this company and the insurance producer named below:

|___|___|___|___|___|___|
Insurance Producer Reference No. THIS INFORMATION MAY NOT BE OMITTED

_____
PRINT Name of Insurance Producer (Last, First, Middle)

|___|___| |___|___| |___|___|
month day Year
Date of Birth

THIS INFORMATION MAY NOT BE OMITTED IF AN INDIVIDUAL PRODUCER

as its Reinsurance Intermediary-Manager Agent in New Jersey commencing |___|___| month |___|___| day |___|___| year for:
Contract Date

all types of insurance for which the company and producer are jointly authorized. The above reinsurance intermediary-manager producer has filed with this company a bond and Errors and Omissions ("E&O") policy in accordance with N.J.A.C. 11:_____

I have determined that the reinsurance intermediary-manager named holds a current New Jersey insurance license, authorizing transaction of the kinds of insurance covered by this contract. We understand that the bond and E&O policy must be updated yearly.

_____ |___|___| _____
Authorized Company Signature Date Phone Number

_____ _____
Print Name and Title Office Address
1 Reinsurance Intermediary-Manager

_____
Date

_____ _____
Insurance Producer Signature Date

Attach a $20.00 company check made payable to: STATE TREASURER OF NEW JERSEY

Attach a copy of the contract between the company and the reinsurance intermediary-manager.

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FORM B

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF TERMINATION OF REINSURANCE INTERMEDIARY-MANAGER

To: Commissioner of Insurance, State of New Jersey

From: |__|__|__|__|__|__|__| _____
Company Reference No. Name of Company

The undersigned hereby gives notice of the termination of the agency contract between this company and the insurance producer named below:

|__|__|__|__|__|__|
Insurance Producer Reference No.

THIS INFORMATION MAY NOT BE OMITTED

_____
PRINT Name of Insurance Producer (Last, First, Middle)

Said contract terminated on |__|__| |__|__| |__|__|
month day Year
Termination Date

Reason for Termination: _____

_____

_____

If the reason for termination is agent misconduct, mail an additional copy of this form to: Director of Enforcement, Department of Insurance, CN 325, Trenton, NJ 08625-0325

_____ |__|__| _____
Authorized Company Signature Date Phone Number

_____ _____
Print Name and Title Office Address

_____
Date

DTREG.1/LRWPC

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FORM C

NEW JERSEY DEPARTMENT OF INSURANCE
LICENSE PROCESSING
CN-327 - 20 W. STATE STREET
TRENTON, NEW JERSEY 07625-0327

APPLICATION FOR RESIDENT OR NON-RESIDENT ORGANIZATION CORPORATION/PARTNERSHIP OR INDIVIDUAL REINSURANCE INTERMEDIARY AUTHORIZATION

A. IDENTIFYING INFORMATION:

Full legal name of organization or individual licensee.

_____

_____

Trade name, if any:

_____

_____

N.J. Producer Reference # _____

B. BUSINESS INFORMATION:

Business Address: If your Business Address is located in New Jersey, then you are a Resident Applicant.

Room No. _____ Suite No. _____ Apt. No. _____

_____
Street Address

P.O. Box No. _____ _____

You must supply a street or location address; a P.O. Box alone is not sufficient. The City, State and Zip Code must reflect the location of the P.O. Box.

_____ _____ _____ - _____
City State Zip Code (include +4, if known)

_____
County (If NJ Resident)

Federal ID Number: _____ - _____

Business Telephone Number: _____ - _____ - _____

Telefax Number, if any: _____ - _____ - _____

NON RESIDENTS ATTACH A CERTIFICATION OF CURRENT LICENSE STATUS ISSUED BY INSURANCE LICENSING AUTHORITY IN HOME STATE SHOWING YOU ARE AUTHORIZED IN YOUR HOME STATE AS A REINSURANCE INTERMEDIARY. (IF YOUR HOME STATE DOES NOT AUTHORIZE REINSURANCE INTERMEDIARIES, PLEASE ATTACH A WRITTEN EXPLANATION.)

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C. IDENTIFICATION OF ALL OFFICERS, PARTNERS, DIRECTORS AND OWNERS OF 5% OR MORE OF THE ORGANIZATION, OR EMPLOYEES DESIGNATED TO ACT AS REINSURANCE INTERMEDIARIES.

(Please Print Cleary or Type)

1. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

2. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

3. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

4. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

5. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

6. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

7. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

8. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

ATTACH ADDITIONAL SHEETS IF NECESSARY

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D. YOU MUST ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX:

1. Have you (or the organization or any officer, partner, director or owner of 5% or more) or designated employee been arrested, indicted or convicted o f a crime, misdemeanor or disorderly person offense in this state, other state, or by the federal government since the effective date of your (their) producer license ? ____ Yes ____ No

   If yes, attach a certified copy of the indictment or judgement of conviction, which may be obtained from the clerk of the court of where the conviction was entered.

2. Have you (or the organization or any officer, partner, director or owner of 5% or more) or designated employee had any business or professional license suspended or revoked since the effective date of your (their) producer license? ____ Yes ____ No

   If yes, attach a copy of order of suspension or revocation from professional or governmental authority.

3. Are you (or any officer, partner, director or owner of 5% or more, if an organization) or designated employee indebted (other than accounts current) to any insurance company, producer or insured or has any judgement been rendered against you, since the effective date of your (their) insurance producer license which has not been satisfied or vacated, for money received from or owned to any insurance company, producer or insured? ____ Yes ____ No

   If yes, attach copies of the judgement and other information concerning the nature of and amount of the indebtedness.

E. I/WE HEREBY CERTIFY THAT:

1. I/WE give the New Jersey Department of Insurance permission to verify any information supplied with any federal state or local government agency.

2. All of the information submitted in this application and all attachments is true and complete. I am/We are aware that submitting false information in connection with this application is grounds for revocation of license and may subject me/us to other civil or criminal penalties.

3. As a licensed officer/partner of the organization or as an individual licensed producer, I understand that I am individually and jointly responsible for the insurance related conduct of the organization or my employees.

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Must be signed by all individuals identified in section C of the previous page. (Attach additional sheets if necessary.)

Signature	Date	Signature	Date
Signature	Date	Signature	Date
Signature	Date	Signature	Date
Signature	Date	Signature	Date

G. FEES:

Application Processing Fee $20.00

Attach one check or money order for the total fee as calculated above, made payable to "State Treasurer of New Jersey."

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PUBLIC NOTICES

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

OFFICE OF LAND AND WATER PLANNING

Notice of Availability of Demonstration Grants Well Head Protection Program

Take notice that, in compliance with P.L. 1987, c.7 (see N.J.S.A. 52:14-34.4, 34.5 and 34.6), the Department of Environmental Protection and Energy (Department) hereby announces the availability of the following grant program funds:

A. Name of program: Well Head Protection Program Demonstration Grants.

B. Purpose: The Well Head Protection Program is required by the 1986 Federal Safe Drinking Water Act (Section 1428) for the purpose of protecting drinking water supply wells from contamination. The Demonstration Grants are funded through the 1981 Water Supply Bond Fund for projects that demonstrate and evaluate methods for the implementation of local well head protection programs. Grant monies may not be used for actual construction of facilities.

C. Amount of money in the grant program: A total of $350,000 will be available in the program in State Fiscal Year 1993.

D. Governmental entities which may apply for funding under the program: Regional public comprehensive planning organizations, interstate and intrastate organizations and coalitions (formal or informal) of municipal governments, county governments and/or environmental commissions, including, but not limit to, the following:

1. Municipal governing bodies, planning departments or boards, health departments or boards, and environmental commissions;
2. County governing bodies, planning departments or boards, health departments or boards and water resource associations;
3. Intrastate regional agencies;
4. Interstate agencies of which New Jersey is a member.

E. Qualifications needed by an applicant to be considered for the program: An applicant for funding must:

1. Have the staff and resources with the capability, expertise, and environmental experience to perform the proposed work;
2. Have the ability and authority to implement the results of the work which is proposed; and
3. Provide matching funds in an amount equivalent to at least 20 percent of the total project amount. The matching funds may consist of either cash, in-kind services, or a combination of both.

F. Procedure for eligible entities to apply for grant funds: An applicant for a grant must submit a letter of intent and a complete grant proposal. The proposal must address each of the following items:

1. The cost of the overall project;
2. The amount of funding requested, and the amount and nature of the matching funds to be provided by the applicant;
3. A specific breakdown of personnel and non-personnel project costs;
4. Staffing and resources which would be devoted to the proposed work;
5. A discussion of the expertise and experience of the applicant in endeavors related to the proposed work activities and with water resources planning in general;
6. Evidence of the ability of the applicant to implement the work products which would result from the proposed work activities;
7. Detailed descriptions of each of the proposed work activities and the work outputs to result from each;
8. A discussion of the ground water system and resources in the study area, including the hydrogeology and ground water use and how the proposed work will help protect, preserve, or enhance the quality of the ground water;
9. A timetable which specifies the anticipated completion date of each task and subtask including the dates by which outputs are to be completed. The timetable should be based on a project duration of 24 months; and
10. A discussion of the portions of the proposed work which the applicant plans to subcontract to other entities and justification for the subcontracting.

G. Project subject: Proposed projects should result in a work product which can be implemented and should pertain to the following subject areas:

Development of a comprehensive regional Well Head Protection Program in accordance with the approved December of 1991 Well Head Protection Program Plan. "Regional" program means groups of contiguous municipalities working together or such groups of municipalities working with county or regional government agencies.

H. Deadline for submittal: Letters of intent from interested parties should be received within two months of the publication of this notice (by November 7, 1993). Complete proposals must be submitted within six months from the publication of this notice (by March 7, 1994).

I. Date by which applicants shall be notified of approval or disapproval: Applicants shall receive notice of preliminary approval or disapproval, pending further project review, of a Well Head Protection Demonstration Grant within 45 days from the application deadline.

J. Further information: Guidelines for the development of a WHPP demonstration grant proposal have been included as part of this notice. Copies of the New Jersey Well Head Protection Program Plan and further information on the program and this grant request for proposal may be obtained from:

Thomas McKee
NJDEPE—Office of Land and Water Planning
CN 423
Trenton, New Jersey 08625
(609) 633-1179

K. Address for letter of intent and applications: All Letters of Intent and proposals for funds should be submitted to:

Daniel J. Van Abs, Assistant Administrator
NJDEPE—Office of Land and Water Planning
CN 423
Trenton, New Jersey 08625

Guidelines for Well Head Protection Demonstration Projects Applications

1.0 Introduction

Ground water provides approximately 50 percent of the drinking water supply for New Jersey. Given the dense population and industrialization of the State, the potential for contamination of this resource is of great concern and increases the need for its protection. The Federal Safe Drinking Water Act of 1986 (Section 1428) requires that all states develop a Well Head Protection Program (WHPP) to target areas for special protection of public community and noncommunity water supplies. The purpose of the New Jersey WHPP is to minimize the risk to public community, public noncommunity and large groupings of domestic wells from pollutant sources by implementing appropriate protection measures ranging from education to pollutant source prohibition.

2.0 Purpose

Funds from the 1981 Water Supply Bond Fund ($350,000) have been specifically appropriated to finance demonstration projects to complement and enhance the state's WHPP. The purpose of this funding is to provide financial assistance in developing regional management programs for the protection of ground water resources and focusing on issues that may not be sufficiently addressed at that level. The results of the demonstration projects would be used as models to assist other areas of the state in developing similar programs.

3.0 Grant Program Specifications

Authorities

WHPP Demonstration Project grants will be awarded through cooperative agreements under the authority of the Department of Environmental Protection and Energy.

Eligibility

Any group of municipalities and/or environmental commissions, county government(s) or regional, interstate or intrastate public comprehensive planning organization is eligible to apply for a WHPP Demonstration Project grant. Priority will be given to projects which propose interagency and intermunicipal agreements. Formal written agreements between cooperating agencies must be in place prior to the grant award. Water

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purveyors and regulated pollutant sources may be included as cooperating agencies but may not apply directly for the grant or receive grant funds unless they are also an eligible entity as defined above.

Availability of Funds

One large grant in the maximum amount of $100,000 will be awarded that focuses on the public noncommunity wells portion of this program. This project will provide guidelines and an implementation plan for the management of Well Head Protection Areas (WHPAs) for the noncommunity wells which can be applied to other areas of the State. Public noncommunity wells are located sporadically throughout the State. Although they serve a large population, such wells are not subject to as stringent monitoring requirements as the public community wells and therefore may be at a greater risk of contamination from point and nonpoint sources of pollution. Preference will be given to proposals from within the Piedmont, Highlands and Valley and Ridge physiographic provinces.

Smaller grants in an amount not to exceed $50,000 for other types of WHPP demonstration projects will also be awarded. The focus of these grants will be the development and implementation of a comprehensive county or regional well head protection plan, in any portion of the state.

Costs

It is the State's intent to award unit price contracts to accomplish the demonstration projects. The project work will consist of those tasks described in an approved Scope of Work (SOW) and any other work the State may determine is necessary to successfully complete the particular project. Entities awarded funding under this program will be required to provide at least 20 percent of the total cost of their project either in dollars or in-kind services. Other state and federal funding will be accepted as matching funds.

4.0 Eligible Activities

Funds that are awarded must be used to support, complement and enhance activities within the New Jersey State WHPP Plan. Projects in all stages of development will be supported but are expected to be comprehensive in nature. Grant funds may be passed through a lead agency to other public agencies, or may be contracted to third parties. The Department prefers that the maximum amount of funding possible be dedicated toward increased local and regional capacity to implement the WHPP over the long term. Contracts should be used primarily for one-time activities that integrally support local implementation.

Examples of eligible activities include but are not limited to:

(1) Advanced delineations of well head protection areas (WHPAs) for public community and/or noncommunity water supply wells;

(2) Application and management of baseline WHPAs for public noncommunity wells;

(3) Delineation of WHPAs for groups of domestic wells;

(4) Nonpoint source pollution management within WHPA;

(5) Development of ordinances;

(6) Protection of future WHPAs;

(7) Coordination of interagency or intermunicipal programs;

(8) Coordination of public and private WHPP;

(9) Pollutant source inventories;

(10) Locational databases;

(11) Geographic Information System data development and use;

(12) Liability education;

(13) Public education and outreach.

5.0 Ineligible Activities

Funds will not be awarded for activities which are currently or will be performed by the Department or are currently required by Department regulation. Such activities include but are not limited to:

(1) Baseline delineations for public community water supply wells;

(2) Water supply contingency plan;

(3) Costs for legal representation in a court of law;

(4) Costs associated with the purchase of land, capital improvements and computer hardware. The purchase of computer equipment or equipment for performing locational related activities is acceptable as in-kind goods.

(5) Costs associated with compliance withpermits or enforcement orders issued by the Department.

6.0 Application Information Requirements

Depending upon the quality of the applications received, it is the intention of the Department to focus efforts equally on projects for entities with ground water protection programs currently in place and for those beginning new programs. All proposals, at a minimum, must include the following items:

(1) A brief introduction outlining the overall approach to complete the total project and illustrating an understanding of the problem that the project is intended to solve.

(2) A descriptive scope of the work to be accomplished within each step or activity and a resultant work product for each. A final publishable report must be submitted to the Department for the project.

(3) A maximum 24-month project schedule appropriate to the effort, indicating submission of appropriate work products. A grant award will terminate 24 months from the date of the award.

(4) A cost projection for each task with total funding requested and in-kind match indicated. All pass-through funds and contractual costs must be clearly defined.

(5) A narrative explanation demonstrating the applicant's commitment for continued implementation of the program. This must include the projected long-term use of any equipment purchased within the scope of the grant award.

7.0 Application Evaluation Criteria

Grant applications will be judged based upon the following criteria:

(1) The degree to which the proposed project complements the state WHPP and incorporates state and regional ground water priorities and goals. Evaluation will be based upon the degree to which the proposed project provides an effective and comprehensive management plan which is designed for continuing implementation. (20 points)

(2) The degree to which the proposed project enhances the development and implementation of an effective local WHPP and sets forth an effective management plan. Evaluation will be based upon the extent to which the project provides a comprehensive management plan involving local authorities and the general public and demonstrates a need for that management. (25 points)

(3) The degree of transferability of the proposed project to other areas of the State. Evaluation will be based on the extent to which the project can be used by other areas throughout the State. (15 points)

(4) The degree to which the proposed project incorporates cooperative efforts between agencies or municipalities. Evaluation will be based upon the extent to which the project fosters communication between interested parties and the strength of the public outreach and education components in the management plan. (20 points)

(5) The degree to which the proposed project promotes sound innovation in WHPP management. Evaluation will consider the incorporation of various levels of technology and the degree to which new, cost-effective techniques can be included in the WHPP management plan. (15 points)

(6) The degree to which the proposed project exceeds the minimum 20 percent local share. (5 points)

7.0 Project Review and Approval

Completed grant applications must be submitted to the Department within six months from the date of this notice. During this six month period, the staff of Rutgers University Ground Water Management Assistance Center will conduct a seminar to discuss the grant proposal process and provide guidance to applicants. Limited assistance will be provided after this seminar to individual applicants by staff of the Department's Office of Land and Water Planning. The grant selection team will be composed of staff of the Department, representatives from the Ground Water Management Assistance Center and other experts as determined by the Department.

The Department will notify applicants of preliminary approval or disapproval within 45 days of the due date. After preliminary approval of the award, the Department may negotiate project tasks and/or monetary awards with the selected applicants.

8.0 Funding Agreement Requirements

All grant recipients must complete an appropriate contract as required by the Department of Environmental Protection and Energy. Recipients are subject to basic recordkeeping, financial documentation and reporting requirements required by the agreement. Recipients will be required to submit monthly progress reports.

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(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Northeast, Upper Raritan, Upper Delaware and Sussex County Water Quality Management Plans

Public Notice

Take notice that on August 10, 1993, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Northeast, Upper Raritan, Upper Delaware and Sussex County Water Quality Management Plans was adopted by the Department. This amendment, proposed by the Musconetcong Sewerage Authority (MSA) and the Sussex County Board of Chosen Freeholders, adopts a Wastewater Management Plan (WMP) for MSA. The WMP identifies a two phase expansion of the MSA Sewage Treatment Plant (STP) and sewer service area. Phase IA would expand the STP to accommodate maximum 30-day average flows of 3.63 million gallons per day (mgd) and expand the sewer service area in Roxbury, Mount Arlington, and Mount Olive Townships. The expanded sewer service area includes out-of-basin areas including areas within the Budd Lake basin. The service area also includes the Boroughs of Netcong and Stanhope. Phase II woulud expand the STP to accommodate maximum 30-day average flows of 5.79 mgd. Hopatcong Borough and Jefferson Township sewer service areas would be accommodated with this Phase II expansion. In addition, the Sussex County Board of Chosen Freeholders, as the designated Sussex County Water Quality Management (WQM) Planning Agency, will retain WMP responsibility for the portions of the Sussex County WQM Plan area which are addressed in this WMP.

This amendment proposal was noticed in the New Jersey Register on May 17, 1993 at 25 N.J.R. 2133(e). Comments on this amendment were received during the public comment period and are summarized below with the DEPE's responses.

COMMENT: The Borough of Hopatcong objected to the MSA WMP because (1) the agreements between MSA and the Borough regarding meeting the sewerage needs of the Borough were not included as part of the WMP, and (2) the affected municipalities were not requested to endorse the agreements between MSA and the Borough.

RESPONSE: Those objections have now been resolved by the adoption by the MSA of a resolution dated July 26, 1993 reaffirming its agreement with the Borough of Hopatcong. In addition, the Borough of Hopatcong has endorsed the WMP in a resolution dated July 26, 1993.

COMMENT: The Delaware River Basin Commission (DRBC) identified concerns relating to the MSA STP and reductions of biochemical oxygen demand from sewage originating from out-of-basin.

RESPONSE: The DRBC's concerns have been addressed by the MSA to the satisfaction of the DRBC as indicated in Docket No. D-92-80 CP.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Lower Raritan/Middlesex County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Lower Raritan/Middlesex County Water Quality Management (WQM) Plan. This amendment proposal was submitted by Van Note-Harvey Associates on behalf of the Township of Plainsboro. This amendment to the Plainsboro Township Wastewater Management Plan is to include Block 6, Lots 8.03 and 14.01 and Block 6.24, Lot 21 into the sewer service area of the Princeton Meadows Utility Company and to remove said lots from the Middlesex County Utilities Authority sewer service area. These tracts of land are zoned R-300 and the intended use of these lands is for public facilities.

This notice is being given to inform the public that a plan amendment has been proposed for the Lower Raritan/Middlesex County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Middlesex County Planning Board, 40 Livingston Avenue, New Brunswick, New Jersey 08901, and the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Middlesex County Planning Board at (908) 745-3016 or the Office of Land and Water Planning at (609) 633-1179.

Middlesex County will hold **a public hearing** on the proposed WQM Plan amendment. The public hearing will be on Thursday, October 7, 1993 at 8:00 P.M., in the Freeholders' Meeting Room, 11th Floor, of the Middlesex County Administration Bulding located on John F. Kennedy Square, New Brunswick, New Jersey. **Interested persons** may submit written comments on the amendment to Mr. William J. Kruse of the Middlesex County Planning Board at the County Planning Board address cited above. A copy of the comments should be sent to Dr. Daniel J. Van Abs at the NJDEPE address cited above. All comments must be submitted within 15 days following the public hearing. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Board of Chosen Freeholders with respect to this amendment request. In addition, if the amendment is adopted by Middlesex County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice and to the public hearing will also be considered by the NJDEPE during its review. Middlesex County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

(c)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Mercer County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Mercer County Water Quality Management (WQM) Plan. This amendment was submitted by Leslie G. London, Esq., on behalf of the Hopewell Valley Regional Board of Education. This amendment will amend the Hopewell Township Wastewater Management Plan to include the Bear Tavern Road Elementary School in the Ewing-Lawrence Sewerage Authority sewer service area. The projected flow from the school will be approximately 6,000 gallons per day.

This notice is being given to inform the public that a plan amendment has been proposed for the Mercer County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Mercer County Planning Division, McDade Administration Building, Room 412, 640 South Broad Street, P.O. Box 8068, Trenton, New Jersey 08650; and the NJDEPE, Office of Land and Water Planning, 401 East State Street, CN 423, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Mercer County Planning Division at (609) 989-6545 or the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to the Secretary, Mercer County Planning Board at the address cited above; and to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 10 working days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Planning Board, the County Executive and by NJDEPE with respect to this amendment request. If significant comments are received, a **public hearing** will be held on October 13, 1993 at 8:30 A.M., in Room 211 of the McDade Administration Building. Notice regarding the decision whether the public hearing as scheduled, will be held, will be published in The Times of Trenton and the Hopewell Valley News on September 22, 1993 or may be verified by calling the Mercer County Division of Planning. If the amendment is adopted by Mercer County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice and to the public hearing will also be considered by the NJDEPE during its review. Mercer County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

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(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that on July 22, 1993, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Tri-County Water Quality Management Plan was adopted by the Department. This amendment updates the Medford Township Wastewater Management Plan (WMP). The amendment expands the sewer service area of the Medford Township Sewage Treatment Plant (STP) to include a portion of the Township known as the Hessert Tract (Block 905, Lot 13) and adjacent existing subdivisions (Block 1001, 1002, 1101, 1102) which are experiencing septic problems, both situated in a Rural Suburban Development zone. An existing restaurant (Block 905, Lot 14), which already is connected to the public sewer system, also lies within the area added to the sewer service area designation. The proposed wastewater flow from the added sites is 13,260 gallons per day. In addition, the WMP update includes a minor revision to Block 2701.20, Lots 9 and part of 10. This revision corrects the service area designation from proposed septic service area to proposed sewer service area. This site presently lies within the sewer service area boundary, of the Medford Township STP, but was improperly labeled as septic service area. Wetlands issues will be addressed by the Pinelands Commission during their review and approval process.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comments on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This amendment proposal was submitted by the Gloucester County Utilities Authority (GCUA). The amendment would adopt the Logan Township Municipal Utilities Authority (LTMUA) Wastewater Management Plan (WMP). This WMP proposes to expand the sewer service area of the LTMUA Sewage Treatment Plant (STP) to serve additional portions of Logan Township. In addition, the WMP clarifies the future sewer service area mapping in Woolwich Township, served by the LTMUA STP, identified in the Tri-County WQM Plan. This clarification bases the sewer service area boundary on existing lot and block lines of parcels presently identified for sewer service in Woolwich Township.

Based on the sewer service area expansion, a projected future (20 year) wastewater planning flow of 3.45 million gallons per day (MGD) for the LTMUA STP is proposed. The WMP identifies all existing NJPDES permitted wastewater discharges and one proposed, currently unpermitted, discharge to ground water of up to 0.072 MGD to service the Logan Asphalt Plant. Those areas of Logan Township not designated as sewer service area will be designated as individual on-site ground water disposal service area of >2,000 gallons per day. The GCUA is presently preparing a regional WMP for its district which includes both municipalities addressed in this WMP.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN 423, 401 East State Street, Trenton, N.J. 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons should submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. James G. Coe, Vice President, Killam Associates, Salem Industrial Park, Bldg. 9, Route 22E, P.O. Box 463, Whitehouse, N.J. 08888. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment (or extend the public comment period in this notice up to 30 additional days). These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this notice to Dr. Van Abs at the NJDEPE address cited above.

If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(c)

DIVISION OF SOLID WASTE MANAGEMENT AND WASTEWATER FACILITIES REGULATION PROGRAM

Notice of Public Hearing and Opportunity for Comment

Statewide Sludge Management Plan Update

DEPE Docket Number: 43-93-07

Take notice that pursuant to N.J.S.A. 13:1E-1 et seq., the Division of Solid Waste Management and the Wastewater Facilities Regulation Program of the Department of Environmental Protection and Energy (DEPE) will hold a **public hearing** on the proposed Statewide Sludge Management Plan Update as follows:

Monday, October 25, 1993
10:00 A.M. to 12:00 noon and
1:00 P.M. to 5:00 P.M. and
6:00 P.M. to 10:00 P.M. (if needed)
DEPE Public Hearing Room
401 East State Street
First Floor, East Wing
Trenton, New Jersey

Submit written comments identified by the Docket Number given above, by November 30, 1993, to:

Janis E. Hoagland, Administrative Practice Officer
NJDEPE Office of Legal Affairs
CN-402
Trenton, New Jersey 08625-0402

The purpose of the hearing is to receive oral and written comments on Section III of the DEPE's Solid Waste Management Plan Update concerning the Statewide Sludge Management Plan Update (hereafter SSMP Update). Pursuant to N.J.S.A. 13:1E-1 et seq., the DEPE has formulated, developed and periodically updated a statewide plan for the environmentally sound management of sewage sludge generated within New Jersey. The SSMP Update includes the various guidelines, recommendations for rules and regulations, and goals, objectives and policies of the DEPE; guidance for the sludge management planning process; and other sludge planning and program components developed to address the state's sludge management needs.

The major focus of the SSMP Update is on goals, objectives and policies for the management of sewage sludge which emanated from the enactment of the Ocean Sludge Dumping Elimination Act (P.L. 1988, c.57) in 1988, N.J.S.A. 58:10A-44 through 46, and the efforts of Governor Florio's Emergency Solid Waste Assessment Task Force (hereafter Governor's Task Force). On April 6, 1990, Governor Florio signed Executive Order Number 8 and appointed the Governor's Task Force to reevaluate New Jersey's solid waste management policies and practices and to recommend appropriate changes. Although the Governor's Task Force focused its efforts on solid waste management policies and implementation strategies, and did not focus upon sewage sludge specifically, its recommendations are relevant conceptually to the DEPE's sludge management policies and approach.

The purpose of the SSMP Update is to formally establish the DEPE's sludge management policy where the beneficial uses of sewage sludge are given full consideration. The policy seeks to continue the DEPE's movement toward the environmentally sound management of sludge as a resource rather than reliance on sludge disposal.

The SSMP Update specifically:

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• Outlines the State's short- and long-term goals and objectives in the areas of pollution prevention, pretreatment, promotion of beneficial use strategies, sludge quality standards, regionalization, self-sufficiency in disposal capacity, as well as the regulatory and policy framework necessary to achieve those goals.

• Describes the current status of sludge management in New Jersey and evaluates the effectiveness of these programs in light of regulatory requirements.

• Establishes a management strategy that is consistent with the Federal program and respects the disposal capacities of other states.

• Provides a "stand alone" document modifying and incorporating relevant information from the original SSMP issued in 1987.

After the public hearing and the close of the comment period, the DEPE will carefully review all comments relevant to the SSMP Update and will prepare a document summarizing the comments and the DEPE's responses thereto, including revisions to the proposed SSMP Update that the DEPE deems necessary and appropriate. Following this, the DEPE intends to adopt the SSMP Update as Section III of the overall Solid Waste Management Plan.

Copies of the proposed SSMP Update are available at all libraries in the State Library depository system, at all county solid waste management offices and will be distributed to all domestic wastewater treatment facilities in New Jersey. In addition, copies may be obtained by writing to the DEPE's Division of Solid Waste Management (DSWM), Bureau of Medical Waste, Residuals Management and Statewide Planning, 840 Bear Tavern Road, Trenton, New Jersey 08625-0414, or by calling the DSWM at (609) 530-8599.

HEALTH

(a)

DIVISION OF ALCOHOLISM, DRUG ABUSE AND ADDICTION SERVICES

Notice of the Availability of the Application for the Prevention and Treatment of Substance Abuse Block Grant; Federal Fiscal Year 1993

Take notice that the Division of Alcoholism, Drug Abuse and Addiction Services has submitted the Application for the Prevention and Treatment of Substance Abuse Block Grant; Federal Fiscal Year 1993 including two Supplemental Revisions, dated June 29, 1993, and July 30, 1993, respectively, to the Federal Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

The Division of Alcoholism and Drug Abuse is making this Application and Revisions public in order to facilitate comment from any person (including any Federal other public agency). Such comment will be considered in developing and preparing the Application for the Prevention and Treatment of Substance Abuse Block Grant; Federal Fiscal Year 1994.

To request a copy of the Application and Revisions write to:

Terence O'Connor, Assistant Commissioner
New Jersey Department of Health
Division of Alcoholism, Drug Abuse and Addiction Services
CN 362, 129 East Hanover Street
Trenton, NJ 08625
Or, by telephone: (609) 292-8949

To provide comment concerning the Application and Revisions write to the Division of Alcoholism, Drug Abuse and Addiction Services not later than 4:30 P.M., October 20, 1993.

(b)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

Notice of Action on Petition for Rulemaking Hospital Licensing Standards N.J.A.C. 8:43G-6.10(c)(2)

Petitioner: Steven J. Picco, Esq., representing New Jersey Health Care Payers Coalition.

Take notice that on June 30, 1993 the New Jersey State Department of Health received a petition from Steven J. Picco, representing the New Jersey Health Care Payers Coalition. The petition requests that the Department amend its hospital licensing standards at N.J.A.C. 8:43G-6.10(c)(2), to allow for public examination of records collected on deaths in anesthetizing locations or intraoperative or postoperative events or outcomes related to anesthesia. Public notice of this petition was published in the New Jersey Register on August 16, 1993 at 25 N.J.R. 3867(b).

In accordance with N.J.A.C. 1:30-3.6 and after thorough review of the petition, the Department has determined that the matter will receive further deliberations. The Department intends to solicit opinions from affected parties, including, but not limited to, the New Jersey Hospital Association, the New Jersey State Society of Anesthesiologists, and consumer representatives.

Upon conclusion of the Department's deliberations, which will end January 15, 1994, the decision will be mailed to the petitioners and published in a future New Jersey Register.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 1:30-3.6.

HUMAN SERVICES

(c)

OFFICE OF THE ASSOCIATE COMMISSIONER

Notice of Availability of Grant Funds

Community Challenge Grants under the Department of Human Services' Minority Males Initiative

Take notice that, in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the New Jersey Department of Human Services hereby announces the availability of the following grant program funds:

A. Name of program: Community Challenge Grant Program for Minority Males.

B. Purpose: The purpose for which these grants are issued is to fund new projects which address the multitude of health, human service, and economic problems afflicting minority males in New Jersey. Specifically, grant funds must be used as start-up money to develop and support activities meeting one of the following goals: family unity; prevent or remedy health conditions in minority males; encourage young men to stay in school and to reach their full potential; prepare the workforce for the technical skills that will be needed in the future; and/or reduce the likelihood that young men will become involved in the criminal justice system. Projects should seek opportunities to empower communities and local organizations to be active participants in creating solutions to the health, human service and economic problems afflicting minority males in New Jersey. Grant funds may be used for personnel, equipment, supplies, domestic travel, and other costs directly related to the project described in the approved application. Funds may not be used for construction of facilities, including additions and extensions, or for the acquisition of land. In addition, funds may not be used to expand existing programs and/or support an existing ongoing agency activity.

C. Amount of available funding for each project: Current funds available equal $200,000. One time only grants of up to a maximum of $15,000 will be awarded to eligible agencies and organizations for the period January 1, 1994 to June 30, 1994.

D. Organizations which may apply for funding under this program: Agencies must be New Jersey based not-for-profit organizations. Eligible applicants may be community coalitions. The applicant is responsible for the management of the project and will serve as the fiscal agent for funds awarded by the State.

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E. Qualifications for receipt of funding under this program: Through written proposals, agencies must demonstrate the capacity to carry out the purposes of the grant, and evaluate the success of their program or activity. Applicants must demonstrate their ability to develop and implement a new innovative project in the community that can provide support to high risk minority males, or foster community solutions to the complex range of problems facing minority males.

F. Procedure for eligible organizations to apply: Agencies may request a copy of the Community Challenge Grant Application in writing from the Office of the Associate Commissioner, New Jersey Department of Human Services, CN 700, Trenton, New Jersey 08625 or via telephone by calling the office at 609/984-7262.

G. Address to which applications must be submitted:

Larry J. Lockhart
Associate Commissioner
New Jersey Department of Human Services
Capital Place One, 5th Floor
CN 700
Trenton, NJ 08625
Attn: Vivian Martin

H. Deadline by which applications must be submitted: 4:30 P.M. on November 5, 1993.

I. Date the applicant is to be notified of acceptance or rejection: No later than December 9, 1993.

(a)

DIVISION OF FAMILY DEVELOPMENT

Notice of Availability of Grant Funds
Hispanic Family Development Program Initiative

Take notice that, in compliance with N.J.S.A. 52:14-34.4, 34.5, and 34.6, the Department of Human Services, Division of Family Development, hereby announces the availability of the following grant program funds.

A. Name of program: Hispanic Family Development Program Initiative.

B. Purpose: To establish programs that offer cross cultural training to county staff involved in the employment, training and case management areas of the Family Development (FDP)/Job Opportunities and Basic Skills (JOBS) Program. The funds awarded will provide for county FDP/JOBS Case Management Staff and Job Training Partnership Act (JTPA)/Service Delivery Agencies and their subcontract providers participating in FDP/JOBS to more effectively service Hispanic FDP/JOBS eligible clients through the provision of a series of cross cultural training work sessions. The ultimate goal of this cross cultural training is to increase the number of Hispanic families participating in the FDP/JOBS Program throughout the State, as well as secure their successful completion and attainment of economic self-sufficiency.

C. Amount of available funding for the program: The total amount of funding available in State Fiscal Year 1994 for the purchase of services under this Request for Proposal (RFP) is $350,000. This funding will be divided among successful statewide, regional and/or county bidders for the reasonable costs associated with the administration of the program and for core program services for the period December 1, 1993 to June 30, 1994.

D. Organizations which may apply for funding under this program: It is the Division's intent to award one or more contracts to the most qualified applicants including but not limited to non-profit Hispanic community based organizations (CBOs); or non-profit professional or service organizations experienced in providing services to Hispanics. Agency proposals must address the following specific services to be provided, and the associated levels of services:

1. Cross cultural awareness training as it pertains to the Hispanic FDP/JOBS participant, including, but not limited to, language, cultural values, communication, barriers to service provision, the Hispanic experience in the welfare system, target outreach and other efforts that will enhance county agency worker services to Hispanics.
2. Staff awareness training as to the Hispanic FDP/JOBS participant's experience in the welfare system.
3. A forum which encourages the identification of barriers within and between systems which may inhibit effective participation in FDP/JOBS by the Hispanic participant.
4. A final report, based upon input from the session conducted, which recommends procedures to enhance the Hispanic participant's understanding and participation in the diverse systems involved in FDP/JOBS.

E. Procedure for eligible organizations to apply: Request for Proposal packages will be available on September 7, 1993. Interested applicants may request an RFP, in writing, from:

Yolanda Aquilar de Neely
FDP Regional Coordinator
Division of Family Development
CN 716
Trenton, New Jersey 08625
Or, by telephone: (609) 588-7914

Additional information and technical assistance will be provided to interested applicants at a Bidders Conference to be held at the Division of Family Development, Quakerbridge Plaza, Building #6, Third Floor, Board Room A, Trenton, New Jersey, on September 22, 1993 at 10:00 A.M.

Request for Proposal packages will be available, upon request, at the Bidders Conference.

F. Address to which applications must be submitted: Applicants should submit one signed original and 10 copies of the completed RFP document and all support materials to:

Yolanda Aquilar de Neely
FDP Regional Coordinator
Division of Family Development
CN 716
Trenton, New Jersey 08625

Please note: For informational purposes an additional copy of the proposal must be sent sent directly to the appropriate Family Development Planning Council for every county to be served by the proposal. Any questions regarding the proposal may be directed to Yolanda Aquilar de Neely at (609) 588-7914.

G. Deadline by which applications must be submitted: The completed RFP document and all required supporting material must be received by the FDP Regional Coordinator, at the above address, by 4:00 P.M. on October 6, 1993.

H. Date the applicant is to be notified of acceptance or rejection: The Department intends to notify successful applicants within 30 days from the application deadline (November 4, 1993) indicating the award is contingent upon contract negotiation.

LAW AND PUBLIC SAFETY

(b)

DIVISION OF CONSUMER AFFAIRS
ACUPUNCTURE EXAMINING BOARD

Notice of Action on Petition for Rulemaking
N.J.A.C. 13:35-9.16
Training Required of a Physician or Dentist

Petitioner: Medical Society of New Jersey.

Take notice that on June 30, 1993, the Acupuncture Examining Board met in public session at 10:25 A.M. and, with a quorum of members present, addressed the Petition for Rulemaking received from the Medical Society of New Jersey (see 25 N.J.R. 3243(a)). Neither the petitioner nor a representative of the petitioner were present at the session. The issue raised was whether to reduce the required number of hours for physician acupuncture training from 300 to 200.

Take further notice that, upon full consideration of the issue, the Board denied the petition for the following reasons:

1. The New Jersey legislature entrusted the Acupuncture Examining Board with responsibility for establishing practice standards and for ensuring that practitioners of acupuncture have received adequate training. To guarantee the public's safety and welfare, certified acupuncturists must hold a bachelor's degree, have completed two years of full-time training at an acupuncture school, have passed a national written exam and a New Jersey oral practical exam, and must update their professional knowledge through continuing education classes. Because none of these requirements apply to physicians practicing acupuncture, the Board believes that a training program of 300 hours is essential to fulfill the mission entrusted to the Board by the State Legislature. Furthermore, the Board noted that none of the training required of physicians is redundant of training in acupuncture and that the training offers fundamental, necessary coverage of principles any acupuncturist must master;

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2. New Jersey is not alone among the states in requiring a minimum 300-hour training program for physicians practicing acupuncture, and based on the Board's direct knowledge of 200-hour training programs it deems those programs to be insufficiently thorough in terms of clinical training and point location, and thereby reaffirms its belief that it is taking the responsible position in insisting on training programs that meet or exceed the 300-hour mark.

Take further notice that for the reasons set forth above, and since the Board did not receive any additional telephone calls, letters or documents from the petitioner beyond an earlier letter and an exemplar of a certificate for a physician who had attended a 200-hour program, the Board voted unanimously to deny the petition for rulemaking.

TRANSPORTATION

(a)

DIVISION OF ROADWAY DESIGN
BUREAU OF UTILITIES AND RAILROAD ENGINEERING

Notice of Public Hearing
Designation of At-grade Crossing as an "Exempt Crossing"
Main Sreet, Riverton Borough, Burlington County

Take notice that the State of New Jersey, Department of Transportation is scheduling a **public hearing** on a recommendation it has received to designate the Main Street at-grade railroad crossing (AAR #501709C) in the Borough of Riverton, County of Burlington as an "Exempt Crossing."

In accordance with New Jersey Motor Vehicles and Traffic Regulations, N.J.S.A. 39:4-128, the Commissioner of Transportation can designate an at-grade railroad crossing as an "Exempt Crossing."

The "Exempt Crossing" designation exempts the driver of any omnibus, designed for carrying more than six passengers or of any school bus carrying any school child or children, or of any vehicle carrying explosive substance or flammable liquids as a cargo or part of a cargo from stopping before crossing the tracks of a railroad. Normally the above such vehicles must come to a complete stop before proceeding across the crossing.

A Diagnostic Team has determined that at the proposed at-grade crossing the potential for damage and injury from accidents between motor vehicles traveling in the same direction exceeds that between a train and the vehicles required to stop by law.

The public hearing will be held on:

Thursday, October 7, 1993
Riverton Public School
Fifth and Howard Street, Riverton Borough
Time: 4:00 to 6:00 P.M.
7:00 to 9:00 P.M.

Persons wishing to make oral presentation are asked to limit their comments to a three to five minute time period. Presenters should bring a copy of their comments to the hearing for use by the Department. A record of the hearing will be made. The hearing record will be kept open for a period of 28 days following the date of the public hearing.

Interested persons may submit written comments until November 4, 1993 to:

Donna Troiano, P.E.
Manager, Bureau of Utility
and Railroad Engineering
1035 Parkway Avenue, CN 600
E&O Building, 6th Floor
Trenton, N.J. 08625

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EXECUTIVE ORDER NO. 66(1978) EXPIRATION DATES

Pursuant to Executive Order No. 66(1978), an administrative rule is assigned an expiration date not to exceed five years from the date of promulgation by a State agency, unless the rule is exempt from the provisions of the order. In the Administrative Code, a single expiration date is affixed at the chapter level and applies to the entire chapter. See N.J.A.C. 1:30-4.4 for an explanation of expiration date assignment.

The following table is a complete listing of established New Jersey Administrative Code expiration dates and exemptions, by Title and Chapter. Current expiration dates may also be found in the loose-leaf volumes of the Administrative Code as a part of the Title Table of Contents for each executive department or agency, on the Subtitle Page for each group of chapters in a Title, and at the beginning of each Chapter.

This listing is published quarterly, in March, June, September and December, in the first issue of the month.

OFFICE OF ADMINISTRATIVE LAW—TITLE 1

N.J.A.C.	Expiration Date
1:1	4/21/97
1:5	9/13/96
1:6	4/21/97
1:6A	3/19/95
1:7	4/21/97
1:10	4/21/97
1:10B	9/13/96
1:11	4/21/97
1:13	4/21/97
1:13A	4/3/94
1:14	7/15/96
1:20	4/21/97
1:21	4/21/97
1:30	1/25/96
1:31	4/21/97

AGRICULTURE—TITLE 2

N.J.A.C.	Expiration Date
2:1	11/19/95
2:1-4	Exempt (28 C.F.R. Part 35)
2:2	1/17/94
2:3	8/21/94
2:5	8/21/94
2:6	EXPIRED RULES
2:9	8/19/96
2:16	1/22/96
2:17	5/31/96
2:18	8/5/96
2:19	10/1/95
2:20	10/1/95
2:21	8/5/96
2:22	6/26/97
2:23	5/28/98
2:24	4/2/95
2:32	5/13/97
2:33	3/6/94
2:34	1/2/95
2:48	10/25/95
2:50	5/1/97
2:52	5/1/95
2:53	1/10/96
2:54	Exempt (7 U.S.C. 601 et seq., 7 C.F.R. 1004)
2:68	11/7/93
2:69	11/7/93
2:70	8/20/95
2:71	7/2/98
2:72	7/2/98
2:74	7/2/98
2:76	7/31/94
2:90	6/22/95

BANKING—TITLE 3

N.J.A.C.	Expiration Date
3:1	1/4/96
3:2	4/12/95
3:3	1/11/95
3:4	8/17/97
3:6	3/1/96
3:7	9/12/95
3:11	5/1/94
3:12	6/15/97
3:13	1/21/97
3:16	6/18/95
3:17	6/13/96
3:18	12/24/97
3:19	3/15/96
3:21	1/24/97
3:22	5/12/94
3:23	7/6/97
3:24	8/18/94
3:25	7/23/97
3:26	12/31/95
3:27	9/12/95
3:28	12/12/94
3:29	8/5/96
3:32	10/3/93
3:33	9/18/94
3:38	9/11/97
3:41	10/11/95
3:42	3/10/98

PERSONNEL—TITLE 4A

N.J.A.C.	Expiration Date
4A:1	9/22/97
4A:2	9/22/97
4A:3	8/5/98
4A:4	5/12/98
4A:5	9/22/97
4A:6	12/22/97
4A:7	9/22/97
4A:8	1/16/95
4A:9	9/22/97
4A:10	9/22/97

COMMUNITY AFFAIRS—TITLE 5

N.J.A.C.	Expiration Date
5:1	2/5/95
5:2	4/10/94
5:3	7/30/98
5:4	9/1/97
5:5	Exempt (28 C.F.R. Part 35)
5:10	11/17/93
5:11	3/10/94
5:12	12/27/94
5:13	6/22/97
5:14	11/9/95
5:15	5/1/94
5:18	1/4/95
5:18A	1/4/95
5:18B	1/4/95
5:18C	2/5/95
5:19	1/15/98
5:20	9/3/96
5:22	2/5/95

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N.J.A.C.	Expiration Date
5:23	2/3/98
5:24	7/10/95
5:25	2/19/96
5:25A	4/20/97
5:26	2/7/96
5:27	5/2/95
5:28	12/13/95
5:29	2/19/96
5:30	5/27/98
5:31	12/1/94
5:33	8/6/95
5:34	12/3/95
5:37	1/7/96
5:50	10/27/93
5:51	8/11/98
5:52	1/2/95
5:70	4/22/97
5:71	6/4/95
5:80	4/20/95
5:91	12/7/97
5:92	2/7/96
5:100	6/18/95

DEPARTMENT OF MILITARY AND VETERANS' AFFAIRS—TITLE 5A

N.J.A.C.	Expiration Date
5A:1	3/12/95
5A:2	5/17/95
5A:3	2/3/97
5A:4	2/3/97
5A:5	9/21/97

EDUCATION—TITLE 6

N.J.A.C.	Expiration Date
6:1	1/11/96
6:2	2/6/94
6:3	6/7/98
6:5	10/22/95
6:7	1/2/95
6:8	12/11/96
6:9	5/3/98
6:11	9/21/95
6:12	3/8/96
6:20	7/16/95
6:21	11/22/94
6:22	7/16/95
6:22A	12/19/93
6:24	1/11/96
6:26	8/3/97
6:28	4/10/94
6:29	2/8/95
6:30	5/11/94
6:31	11/16/94
6:39	8/14/94
6:43	8/10/95
6:46	4/10/94
6:51	8/5/96
6:53	4/10/97
6:64	9/14/97
6:68	2/26/95
6:70	10/17/94
6:78	11/7/93

ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7

N.J.A.C.	Expiration Date
7:1	8/15/95
7:1A	5/22/97
7:1C	6/15/95
7:1D	11/28/93
7:1E	9/3/96
7:1F	4/16/97
7:1G	9/29/94
7:1H	7/13/95
7:1I	5/28/98
7:1J	1/4/98
7:1K	3/1/98
7:2	10/7/96
7:3	6/21/98
7:4	8/17/97
7:4A	9/18/94
7:5	11/19/95
7:5A	6/17/98
7:5B	6/24/98
7:5C	1/16/95
7:6	6/9/94
7:7	5/12/94
7:7A	3/16/97
7:7E	7/24/95
7:7F	1/19/93
7:8	2/5/98
7:9	1/18/96
7:9A	8/21/94
7:10	9/1/94
7:11	5/3/98
7:12	11/24/97
7:13	7/14/94
7:14	4/27/94
7:14A	6/2/94
7:14B	11/18/97
7:15	10/2/94
7:18	7/3/96
7:19	2/26/95
7:19A	3/19/95
7:19B	3/19/95
7:20	5/2/95
7:20A	12/16/93
7:22	12/27/96
7:22A	2/5/95
7:23	6/9/94
7:24	4/22/96
7:25	2/15/96
7:25A	4/23/95
7:26	10/25/95
7:26A	11/18/96
7:26B	11/18/97
7:26C	5/17/98
7:26E	6/7/98
7:27	Exempt
7:27A	12/4/94
7:27B	Exempt
7:28	7/30/95
7:29	5/21/95
7:29B	2/1/93
7:30	11/24/97
7:31	6/18/98
7:32	7/6/98
7:36	11/21/93
7:38	9/18/95
7:45	2/6/94
7:50	Exempt
7:60	3/2/97
7:61	5/17/98

HEALTH—TITLE 8

N.J.A.C.	Expiration Date
8:2	8/16/98
8:7	9/14/95
8:8	4/12/94
8:9	2/14/96
8:13	9/8/97
8:18	11/6/94
8:19	5/11/95
8:20	3/2/95
8:21	10/23/95
8:21A	8/3/97

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N.J.A.C.	Expiration Date
8:22	7/11/96
8:23	12/13/94
8:24	4/14/98
8:25	5/11/98
8:26	4/12/96
8:31	1/16/95
8:31A	2/20/95
8:31B	8/17/95
8:31C	4/20/97
8:33	7/27/95
8:33A	11/25/97
8:33B	7/27/95
8:33C	9/8/97
8:33E	EXPIRED RULES
8:33F	11/16/94
8:33H	9/8/97
8:33I	2/16/95
8:33J	4/24/94
8:33K	3/27/94
8:33L	11/16/92
8:33M	7/17/94
8:33N	5/15/94
8:33P	3/19/95
8:33Q	11/19/95
8:33R	12/11/94
8:34	11/15/93
8:35A	9/8/97
8:38	4/3/94
8:39	6/14/98
8:40	12/6/96
8:41	6/21/98
8:41A	2/18/97
8:42	8/17/97
8:42A	6/19/94
8:42B	6/14/98
8:43	11/19/94
8:43A	8/16/98
8:43F	2/20/95
8:43G	2/5/95
8:43H	8/21/94
8:44	11/2/93
8:45	2/7/95
8:51	9/17/95
8:52	12/11/96
8:57	4/20/95
8:57A	4/20/95
8:59	9/29/94
8:60	5/3/95
8:61	10/4/96
8:65	6/17/96
8:66	3/5/95
8:66A	3/5/95
8:70	6/14/98
8:71	2/17/94
8:80	4/6/97
8:100	7/20/97

HIGHER EDUCATION—TITLE 9

N.J.A.C.	Expiration Date
9:1	2/21/94
9:2	5/4/95
9:3	9/27/93
9:4	9/26/96
9:5	4/1/96
9:6	4/30/95
9:6A	3/15/98
9:7	11/6/97
9:8	10/15/95
9:9	8/16/98
9:11	4/17/94
9:12	4/17/94
9:14	4/11/95
9:15	8/21/94
9:16	1/19/98

HUMAN SERVICES—TITLE 10

N.J.A.C.	Expiration Date
10:1A	5/12/98
10:2	12/11/96
10:3	11/21/93
10:6	1/7/96
10:7	1/21/97
10:11	1/16/95
10:12	12/23/96
10:13	7/18/93
10:14	5/7/98
10:15	1/1/95
10:15A	1/1/95
10:15B	1/1/95
10:15C	1/1/95
10:16	12/21/97
10:31	6/5/94
10:35	9/21/97
10:36	12/29/97
10:37	11/2/95
10:38	4/29/96
10:38A	7/19/98
10:39	5/7/95
10:40	5/11/94
10:41	3/20/94
10:42	8/19/96
10:43	8/21/94
10:44A	11/21/93
10:44B	7/16/95
10:45	2/20/95
10:46	9/17/95
10:47	11/2/95
10:48	12/19/95
10:49	8/17/97
10:50	2/27/96
10:51	9/7/98
10:52	2/8/95
10:53	4/27/95
10:53A	11/2/97
10:54	2/15/96
10:55	3/8/95
10:56	8/21/96
10:57	2/13/96
10:58	2/22/96
10:59	2/15/96
10:60	2/19/96
10:61	2/15/96
10:62	12/19/93
10:63	11/28/94
10:64	2/22/96
10:65	2/19/96
10:66	12/15/93
10:67	2/19/96
10:68	6/28/96
10:69	5/14/98
10:69A	3/26/98
10:69B	11/21/93
10:70	6/7/96
10:71	12/24/95
10:72	8/24/97
10:73	7/15/96
10:80	5/19/94
10:81	8/24/94
10:82	8/24/94
10:83	11/2/97
10:85	12/20/94
10:86	9/21/97
10:87	1/27/94
10:89	5/24/95
10:90	10/14/92
10:91	9/4/95
10:95	Exempt
10:97	5/15/94
10:99	6/4/95
10:109	2/4/96
10:120	7/9/96
10:121	7/16/95

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N.J.A.C.	Expiration Date
10:121A	11/25/97
10:122	5/15/94
10:122A	Exempt
10:122B	1/4/98
10:122C	1/4/98
10:122D	1/4/98
10:122E	1/4/98
10:123	7/13/95
10:123A	8/17/97
10:124	11/4/97
10:125	6/4/95
10:126	11/7/93
10:126A	5/7/95
10:127	8/16/98
10:128	2/19/96
10:129	7/13/95
10:130	7/2/95
10:131	10/7/97
10:132	10/25/96
10:133	1/4/98
10:133A	1/4/98
10:133B	1/4/98
10:133C	1/4/98
10:141	2/7/94
10:150	10/22/97

CORRECTIONS—TITLE 10A

N.J.A.C.	Expiration Date
10A:1	6/1/97
10A:2	2/5/95
10A:3	9/16/96
10A:4	5/7/96
10A:5	6/17/96
10A:6	10/27/97
10A:8	8/19/97
10A:9	2/18/97
10A:10	7/9/97
10A:16	7/6/97
10A:17	2/3/97
10A:18	5/27/97
10A:19	8/21/94
10A:20	2/18/97
10A:21	2/4/96
10A:22	7/5/93
10A:23	7/6/97
10A:31	3/5/95
10A:32	4/16/95
10A:33	5/2/94
10A:34	4/6/97
10A:35	4/15/96
10A:70	Exempt
10A:71	2/5/95

INSURANCE—TITLE 11

N.J.A.C.	Expiration Date
11:1	1/31/96
11:2	11/30/95
11:3	1/4/96
11:4	11/30/95
11:5	10/28/93
11:6	7/6/98
11:7	9/25/97
11:10	7/12/95
11:12	9/27/96
11:13	11/10/97
11:15	10/26/94
11:16	1/31/96
11:17	4/15/98
11:17A	1/2/95
11:17B	1/2/95
11:17C	1/2/95
11:17D	1/2/95
11:18	12/18/94
11:19	2/1/98
11:20	8/13/98

LABOR—TITLE 12

N.J.A.C.	Expiration Date
12:3	12/19/93
12:5	9/19/93
12:6	10/17/93
12:15	7/30/95
12:16	3/23/95
12:17	1/4/96
12:18	3/5/98
12:19	7/2/95
12:20	8/14/94
12:35	7/16/95
12:40	2/5/95
12:41	1/17/94
12:45	5/2/93
12:51	11/22/96
12:55	12/16/96
12:56	9/26/95
12:57	9/26/95
12:58	9/26/95
12:60	3/19/98
12:61	12/16/96
12:90	12/15/94
12:100	9/22/94
12:102	5/21/95
12:105	1/11/96
12:110	1/8/98
12:112	9/6/93
12:120	5/3/95
12:175	11/28/93
12:190	2/1/98
12:195	6/14/98
12:196	8/6/95
12:200	8/3/95
12:210	12/16/96
12:235	5/3/96

COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A

N.J.A.C.	Expiration Date
12A:9	5/28/98
12A:10-1	10/13/94
12A:11	4/30/98
12A:12	9/21/92
12A:31	7/16/95
12A:50	8/15/93
12A:54	8/15/93
12A:60	11/21/93
12A:80	7/2/95
12A:100	7/17/96
12A:120	7/27/98
12A:121	12/5/93

LAW AND PUBLIC SAFETY—TITLE 13

N.J.A.C.	Expiration Date
13:1	6/9/98
13:2	7/24/95
13:3	5/17/98
13:4	1/17/96
13:10	3/27/94
13:13	7/16/95
13:14	9/16/96
13:18	3/30/95
13:19	8/18/94
13:20	12/13/95
13:21	12/13/95
13:23	5/26/94

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N.J.A.C.	Expiration Date
13:24	9/27/94
13:25	3/16/95
13:26	7/29/98
13:27	2/20/95
13:28	5/14/98
13:29	5/23/95
13:30	3/12/95
13:31	11/20/96
13:32	10/21/97
13:33	3/12/95
13:34	10/26/93
13:35	9/21/94
13:36	9/27/94
13:37	1/23/95
13:38	8/27/95
13:39	6/19/94
13:39A	6/21/96
13:40	8/3/95
13:40A	12/16/96
13:41	7/17/95
13:42	10/31/93
13:43	9/1/93
13:44	8/7/94
13:44B	11/2/97
13:44C	7/8/98
13:44D	8/7/94
13:44E	7/1/96
13:44F	6/15/97
13:44G	1/4/98
13:45A	11/9/95
13:45B	9/21/97
13:46	9/4/95
13:47	1/27/97
13:47A	10/2/97
13:47B	2/21/94
13:47C	6/9/94
13:47K	9/17/95
13:48	1/17/96
13:49	12/16/93
13:51	9/16/96
13:54	11/18/96
13:59	7/30/95
13:60	1/16/97
13:61	3/5/95
13:62	3/19/95
13:63	8/19/96
13:70	1/25/95
13:71	1/25/95
13:72	1/19/98
13:75	6/5/94
13:76	4/16/98
13:77	1/22/98
13:78	3/20/94
13:80	9/17/95
13:81	8/6/95

PUBLIC UTILITIES—TITLE 14

N.J.A.C.	Expiration Date
14:1	6/1/97
14:3	5/6/96
14:5	12/2/96
14:5A	1/4/98
14:6	9/3/96
14:9	4/1/96
14:10	9/6/96
14:11	3/1/98
14:12	11/4/96
14:17	4/24/94
14:18	7/26/95
14:25	3/5/95
14:29	3/4/96
14:30	2/19/96
14:32	1/22/96
14:38	4/1/96

ENERGY—TITLE 14A

N.J.A.C.	Expiration Date
14A:6	1/16/95
14A:8	1/16/95
14A:11	1/16/95
14A:13	EXPIRED RULES
14A:14	1/30/94

STATE—TITLE 15

N.J.A.C.	Expiration Date
15:2	4/12/98
15:3	8/19/96
15:5	7/6/97
15:10	4/15/96

PUBLIC ADVOCATE—TITLE 15A

N.J.A.C.	Expiration Date
15A:2	12/27/94

TRANSPORTATION—TITLE 16

N.J.A.C.	Expiration Date
16:1	10/1/95
16:1A	6/16/94
16:4	9/16/96
16:5	11/20/94
16:6	8/7/94
16:7	3/6/94
16:20A	2/20/95
16:20B	2/20/95
16:21	8/6/95
16:21A	11/20/94
16:21B	12/3/95
16:22	12/18/95
16:24	2/5/95
16:25	8/9/98
16:25A	5/13/98
16:26	9/5/94
16:27	4/8/96
16:28	5/7/98
16:28A	5/7/98
16:29	5/7/98
16:30	5/7/98
16:31	5/7/98
16:31A	5/7/98
16:32	2/8/95
16:38	10/15/95
16:41	9/8/97
16:41B	7/2/95
16:41C	5/4/97
16:43	5/10/95
16:44	5/25/93
16:45	9/18/94
16:46	11/6/94
16:47	4/20/97
16:49	2/8/95
16:51	2/14/97
16:53	7/17/94
16:53B	7/3/94
16:53C	5/13/98
16:53D	5/3/94
16:54	7/6/98
16:55	5/13/98
16:56	8/7/94
16:60	5/13/98
16:61	5/13/98
16:62	2/26/95
16:72	3/20/96
16:73	5/18/97
16:74	12/16/96
16:75	5/13/93
16:76	2/6/94
16:77	3/5/95

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N.J.A.C.	Expiration Date
16:78	12/17/95
16:79	9/12/96
16:80	11/7/93
16:81	11/7/93
16:82	9/5/94
16:83	1/19/98

TREASURY-GENERAL—TITLE 17

N.J.A.C.	Expiration Date
17:1	5/1/98
17:2	11/8/94
17:3	8/15/93
17:4	6/8/95
17:5	11/30/95
17:6	11/22/93
17:7	12/19/93
17:8	10/15/95
17:9	10/3/93
17:10	5/1/98
17:12	10/13/94
17:13	10/13/94
17:14	10/13/94
17:16	5/2/96
17:19	3/8/95
17:20	6/1/98
17:25	5/26/94
17:27	10/7/93
17:28	8/17/95
17:29	9/26/95
17:30	3/11/97
17:32	3/19/98
17:33	4/17/94
17:40	11/19/95
17:41	4/1/96
17:42	9/8/97

TREASURY-TAXATION—TITLE 18

N.J.A.C.	Expiration Date
18:1	7/21/94
18:2	9/6/93
18:3	3/14/94
18:5	3/14/94
18:6	3/14/94
18:7	3/14/94
18:8	2/24/94
18:9	6/4/98
18:12	7/29/93
18:12A	7/29/93
18:14	7/29/93
18:15	7/29/93
18:16	7/29/93
18:17	7/29/93
18:18	3/14/94
18:18A	2/3/97
18:19	3/14/94
18:21	2/19/96
18:22	2/24/94
18:23	2/24/94
18:23A	9/4/95
18:24	6/4/98
18:25	2/19/96
18:26	6/4/98
18:35	6/4/98
18:36	3/19/95
18:37	7/23/95
18:38	2/1/98
18:39	9/8/92

OTHER AGENCIES—TITLE 19

N.J.A.C.	Expiration Date
19:3	3/29/98
19:3A	11/4/96
19:3B	3/29/98
19:4	3/29/98
19:4A	3/29/98
19:6	5/6/96
19:8	5/17/98
19:9	10/17/93
19:10	9/5/94
19:11	8/20/95
19:12	7/17/96
19:14	8/20/95
19:16	7/17/96
19:17	6/7/98
19:18	5/21/95
19:20	2/5/95
19:25	10/1/95
19:30	7/23/95
19:31	8/20/95
19:40	8/24/94
19:41	4/15/95
19:42	8/15/95
19:43	12/21/97
19:44	12/15/96
19:45	8/15/97
19:46	4/15/98
19:47	4/15/96
19:48	10/13/93
19:49	9/18/97
19:50	12/15/93
19:51	4/27/94
19:53	12/15/95
19:54	12/15/94
19:55	1/19/98
19:61	3/2/97
19:65	10/5/97
19:75	1/13/94

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REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the July 6, 1993 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1993 d.1 means the first rule filed for 1993.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT JUNE 21, 1993

NEXT UPDATE: SUPPLEMENT JULY 19, 1993

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

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N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
24 N.J.R. 2971 and 3202	September 8, 1992
24 N.J.R. 3203 and 3454	September 21, 1992
24 N.J.R. 3455 and 3578	October 5, 1992
24 N.J.R. 3579 and 3784	October 19, 1992
24 N.J.R. 3785 and 4144	November 2, 1992
24 N.J.R. 4145 and 4306	November 16, 1992
24 N.J.R. 4307 and 4454	December 7, 1992
24 N.J.R. 4455 and 4606	December 21, 1992
25 N.J.R. 1 and 218	January 4, 1993
25 N.J.R. 219 and 388	January 19, 1993
25 N.J.R. 389 and 616	February 1, 1993
25 N.J.R. 619 and 736	February 16, 1993
25 N.J.R. 737 and 1030	March 1, 1993
25 N.J.R. 1031 and 1308	March 15, 1993
25 N.J.R. 1309 and 1620	April 5, 1993
25 N.J.R. 1621 and 1796	April 19, 1993
25 N.J.R. 1797 and 1912	May 3, 1993
25 N.J.R. 1913 and 2150	May 17, 1993
25 N.J.R. 2151 and 2620	June 7, 1993
25 N.J.R. 2621 and 2794	June 21, 1993
25 N.J.R. 2795 and 3050	July 6, 1993
25 N.J.R. 3051 and 3276	July 19, 1993
25 N.J.R. 3277 and 3582	August 2, 1993
25 N.J.R. 3583 and 3884	August 16, 1993
25 N.J.R. 3885 and 4360	September 7, 1993

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:13A-1.1, 14.2, 14.4, 18.1, 18.3	Lemon Law hearings	25 N.J.R. 2625(a)	R.1993 d.422	25 N.J.R. 4063(a)
Most recent update to Title 1: TRANSMITTAL 1993-1 (supplement June 21, 1993)				
AGRICULTURE—TITLE 2				
2:1-4	Disability discrimination grievance procedure: administrative correction	———	———	25 N.J.R. 2859(a)
2:6	Animal health: biological products for diagnostic or therapeutic purposes	24 N.J.R. 2974(a)		
2:6	Animal health: extension of comment period regarding biological products for diagnostic or therapeutic purposes	24 N.J.R. 3981(a)		
2:23	Gypsy moth suppression program	25 N.J.R. 1627(a)	R.1993 d.305	25 N.J.R. 2686(a)
2:69-1.11	Commercial values of primary plant nutrients	25 N.J.R. 3585(a)		
2:71	Grades and standards	25 N.J.R. 1801(a)	R.1993 d.379	25 N.J.R. 3453(a)
2:71-2.26	Grades and standards: administrative correction	———	———	25 N.J.R. 3453(b)
2:72	Bonding requirement of commission merchants, dealers, brokers, agents	25 N.J.R. 1802(a)	R.1993 d.378	25 N.J.R. 3453(c)
2:74	Controlled atmosphere storage apples	25 N.J.R. 1803(a)	R.1993 d.377	25 N.J.R. 3453(d)
2:76-5.1-5.4	Soil and water conservation project cost-sharing	25 N.J.R. 3279(a)		
2:76-6.2-6.11, 6.13, 6.16, 6.17	Farmland Preservation Program: acquisition of development easements	25 N.J.R. 1804(a)	R.1993 d.392	25 N.J.R. 3453(e)
2:76-10	Farmland Appraisal Handbook Standards	25 N.J.R. 1811(a)	R.1993 d.391	25 N.J.R. 3461(a)
Most recent update to Title 2: TRANSMITTAL 1993-4 (supplement June 21, 1993)				
BANKING—TITLE 3				
3:1-12.4	Multiple party deposit accounts: administrative correction	———	———	25 N.J.R. 2860(a)
3:1-13.2	Mortgage loans: fire insurance amount	25 N.J.R. 3585(b)		
3:1-16.2, 16.3	Fees; mortgage banker non-servicing	25 N.J.R. 2625(b)	R.1993 d.423	25 N.J.R. 4063(b)
3:2-1.4	Mortgage banker non-servicing	25 N.J.R. 1035(a)	R.1993 d.295	25 N.J.R. 2687(a)
3:2-1.4	Mortgage banker non-servicing	25 N.J.R. 2625(b)	R.1993 d.423	25 N.J.R. 4063(b)
3:3-3	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(b)	R.1993 d.321	25 N.J.R. 2860(a)
3:4-2	Payment of stock options to directors, officers and employees of State depositories	25 N.J.R. 3586(a)		
3:6-15.2	Disqualification of savings bank directors	25 N.J.R. 3586(b)		
3:11-7.11	Disqualification of bank directors	25 N.J.R. 3586(b)		
3:28-4.7, 4.12	Repair and improvement loans	25 N.J.R. 3587(a)		
3:31	Repeal (see 3:28-4.7, 4.12)	25 N.J.R. 3587(a)		
3:32	Conversion of associations and savings banks	25 N.J.R. 2799(a)		
3:38-1.1, 1.10, 5.1	Mortgage banker non-servicing	25 N.J.R. 1035(a)		
3:38-1.3, 4.1	Mortgage banker—mortgage banker non-servicing conversion; fees	25 N.J.R. 2625(b)	R.1993 d.423	25 N.J.R. 4063(b)
3:41-2.1, 11	Cemetery Board: location of interment spaces and path access	25 N.J.R. 623(a)		
Most recent update to Title 3: TRANSMITTAL 1993-5 (supplement June 21, 1993)				

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
CIVIL SERVICE—TITLE 4				
Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)				
PERSONNEL—TITLE 4A				
4A:1-5	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(c)		
4A:3	Classification, services and compensation	25 N.J.R. 1916(a)	R.1993 d.424	25 N.J.R. 4064(a)
Most recent update to Title 4A: TRANSMITTAL 1993-4 (supplement June 21, 1993)				
COMMUNITY AFFAIRS—TITLE 5				
5:3	Department records	25 N.J.R. 2157(a)	R.1993 d.419	25 N.J.R. 4071(a)
5:5	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA))	25 N.J.R. 1315(a)	R.1993 d.373	25 N.J.R. 3509(a)
5:10	Maintenance of hotels and multiple dwellings	25 N.J.R. 2627(a)		
5:18-3.2, 3.3, 3.13, 3.19, App. 3A	Fire Prevention Code: junk yards, recycling centers, and other exterior storage sites	25 N.J.R. 1315(b)		
5:18-4.3, 4.7	Fire Safety Code: fire suppression systems in hospitals and nursing homes	25 N.J.R. 1316(a)		
5:18C-4.2, 5.2, 5.3, 5.4	Fire service training and certification	25 N.J.R. 1846(a)	R.1993 d.440	25 N.J.R. 4071(b)
5:23-1.4, 2.7, 2.17A	Uniform Construction Code: minor work; ordinary repairs	25 N.J.R. 3692(a)		
5:23-1.4, 2.16, 2.17	Uniform Construction Code: prior approvals; abandoned wells	25 N.J.R. 2158(a)	R.1993 d.420	25 N.J.R. 4072(a)
5:23-1.6, 2.15, 4.18	Uniform Construction Code: prototype plan review	25 N.J.R. 1629(a)	R.1993 d.353	25 N.J.R. 3147(a)
5:23-2.7, 9.3	Uniform Construction Code: ordinary repairs; interpretation	25 N.J.R. 2159(a)		
5:23-2.23	Uniform Construction Code: ventilation system requirements in Class I and II business and education buildings	25 N.J.R. 2161(a)	R.1993 d.421	25 N.J.R. 4073(a)
5:23-4.4, 4.5, 4.5A, 4.12, 4.14, 4.18, 4.20	Uniform Construction Code: private on-site inspection agencies	25 N.J.R. 2162(a)		
5:23-4.5	Uniform Construction Code: "Notice of Elevator Device Sealed Out of Operation"	25 N.J.R. 3693(a)		
5:23-8	Asbestos Hazard Abatement Subcode: administrative corrections	_____	_____	25 N.J.R. 2862(a)
5:26-8.2	Meetings of community associations	25 N.J.R. 3693(b)		
5:50	State Review Process for intergovernmental review of applications for Federal financial assistance and direct development activities	25 N.J.R. 3281(a)		
5:51	Handicapped persons recreational opportunities	25 N.J.R. 2633(a)	R.1993 d.436	25 N.J.R. 4074(a)
5:70-6.3	Congregate Housing Services Program: service subsidy formula	25 N.J.R. 2634(a)	R.1993 d.437	25 N.J.R. 4075(a)
5:80-23	Housing and Mortgage Finance Agency: Housing Incentive Note Purchase Program	25 N.J.R. 1847(a)	R.1993 d.370	25 N.J.R. 3148(a)
5:80-23.9	Housing and Mortgage Finance Agency: Housing Incentive Note Purchase Program fees	25 N.J.R. 3053(a)		
5:91-14	Council on Affordable Housing: interim procedures	25 N.J.R. 1118(a)	R.1993 d.407	25 N.J.R. 3753(a)
5:92-1.1	Council on Affordable Housing: substantive rules	25 N.J.R. 1118(a)		
5:93	Council on Affordable Housing: substantive rules	25 N.J.R. 1118(a)		
Most recent update to Title 5: TRANSMITTAL 1993-6 (supplement June 21, 1993)				
MILITARY AND VETERANS' AFFAIRS—TITLE 5A				
5A:7-1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1317(a)		
Most recent update to Title 5A: TRANSMITTAL 1992-2 (supplement September 21, 1992)				
EDUCATION—TITLE 6				
6:3-9	School Ethics Commission	25 N.J.R. 1924(a)	R.1993 d.394	25 N.J.R. 3511(a)
6:22A	School facility lease purchase agreements	25 N.J.R. 3588(a)		
6:28-1.1, 1.3, 2.3, 2.6, 2.7, 3.2, 3.7, 4.1–4.4, 7.5, 8.4, 9.2, 10.1, 10.2, 11.2, 11.4, 11.9	Special education	25 N.J.R. 1318(a)	R.1993 d.393	25 N.J.R. 3515(a)
6:78	Marie H. Katzenbach School for the Deaf	25 N.J.R. 3592(a)		
Most recent update to Title 6: TRANSMITTAL 1993-5 (supplement June 21, 1993)				

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ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7				
7:0	Well construction and sealing: request for public comment regarding comprehensive rules	24 N.J.R. 3286(a)		
7:0	Green glass marketing and recycling: request for public input on feasibility study	25 N.J.R. 1654(a)		
7:0	Regulated Medical Waste Management Plan: public hearing and opportunity for comment	25 N.J.R. 1654(b)		
7:0	Site Remediation Program: analysis of strict, joint and several liability under the New Jersey Spill Compensation Act	25 N.J.R. 3694(a)		
7:1D	Allocation of water supply costs for emergency water projects	25 N.J.R. 2635(a)		
7:1E	Discharges of petroleum and other hazardous substances: request for public comment on draft amendments	25 N.J.R. 2636(a)		
7:1F-2.2, App. A	Environmental Hazardous Substances and Industrial Survey lists: copper phthalocyanine compounds; confidentiality	25 N.J.R. 2166(a)	R.1993 d.408	25 N.J.R. 3754(a)
7:1G-1–5, 7	Worker and Community Right to Know	25 N.J.R. 1631(a)		
7:1G-1.2, 6.1–6.11, 6.13-6.16	Worker and Community Right to Know Act: trade secrets and definitions	25 N.J.R. 858(a)	R.1993 d.386	25 N.J.R. 3537(a)
7:1G-2.1, 6.4	Environmental Hazardous Substances and Industrial Survey lists: copper phthalocyanine compounds; confidentiality	25 N.J.R. 2166(a)		
7:1K-1.5, 3.1, 3.4, 3.9-3.11, 4.3, 4.5, 4.7, 5.1, 5.2, 6.1, 6.2, 7.2, 7.3, 9.2-9.5, 9.7, 12.6-12.9	Pollution Prevention Program requirements	25 N.J.R. 1849(a)		
7:2-2.20, 3.6, 6.4, 8.4, 8.6, 10.2, 16.5, 17.1, 17.3, 17.4, 17.5	State Park Service Code	25 N.J.R. 2799(b)		
7:4B	Historic Preservation Revolving Loan Program	25 N.J.R. 748(a)		
7:5A	Natural Areas System	25 N.J.R. 1350(a)	R.1993 d.350	25 N.J.R. 3150(a)
7:5B	Open lands management	25 N.J.R. 1354(a)	R.1993 d.359	25 N.J.R. 3153(a)
7:7A-1.4, 2.7	Freshwater Wetlands Protection Act rules: definition of project	25 N.J.R. 1642(a)		
7:7E-7.4	Coastal zone management: Outer Continental Shelf oil and gas exploration and development	25 N.J.R. 5(a)		
7:9-1.1	Treatment works approval, sewer bans and sewer ban exemptions	25 N.J.R. 3282(a)		
7:9-4	Surface water quality standards: request for public comment on draft Practical Quantitation Levels	24 N.J.R. 4008(a)		
7:9-4 (7:9B)	Surface water quality standards; draft Practical Quantitation Levels; total phosphorus limitations and criteria: extension of comment periods and notice of roundtable discussion	25 N.J.R. 404(a)		
7:9-4 (7:9B-1), 6.3	Surface water quality standards	24 N.J.R. 3983(a)		
7:9-4.5, 4.14, 4.15	Surface water quality standards	25 N.J.R. 405(a)	R.1993 d.415	25 N.J.R. 3755(a)
7:9-4.14 (7:9B-1.14)	NJPDES program and surface water quality standards: request for public comment regarding total phosphorous limitations and criteria	24 N.J.R. 4008(b)		
7:9-4.14, 4.15 (7:9B-1.14, 1.15)	Surface water quality standards: administrative corrections to proposal	24 N.J.R. 4471(a)		
7:9-4.15	Water surface quality standards: Wallkill River	25 N.J.R. 3755(a)		
7:14-8.4	Request for adjudicatory hearing on penalty assessment for violations of Water Pollution Control Act: administrative correction	———	———	25 N.J.R. 2862(b)
7:14A	NJPDES Program: opportunity for interested party review of permitting system	25 N.J.R. 411(a)		
7:14A	NJPDES Program: extension of comment period for interested party review of permitting system	25 N.J.R. 1863(a)		
7:14A-1.8	NJPDES Program fees	25 N.J.R. 1358(a)		
7:14A-1.9, 3.14	Surface water quality standards	24 N.J.R. 3983(a)		
7:14A-1.9, 12, 22, 23	Treatment works approval, sewer bans and exemptions	25 N.J.R. 3282(a)		
7:14B-1.6, 2.2, 2.6, 2.7, 2.8, 3.1–3.8	Underground Storage Tanks Program fees	25 N.J.R. 1363(a)		
7:15-5.18	Treatment works approval, sewer bans and exemptions	25 N.J.R. 3282(a)		
7:22-9.1, 9.2, 9.4, 9.11–9.15, 10.1, 10.2, 10.4, 10.5, 10.6	Sewage Infrastructure Improvement Act grants: interconnection and cross-connection abatement	25 N.J.R. 1643(a)	R.1993 d.409	25 N.J.R. 3760(a)

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7:22A-1.4, 1.5, 1.7, 1.12, 1.15, 1.16, 2.4, 2.5, 2.6, 2.8, 3.4, 4.2, 4.5, 4.8, 4.11, 6.1–6.9, 6.11, 6.12, 6.14, 6.15, 7	Sewage Infrastructure Improvement Act grants: interconnection and cross-connection abatement	25 N.J.R. 1643(a)	R.1993 d.409	25 N.J.R. 3760(a)
7:25-1.5	Fish and Game Council: license, permit and stamp fees	25 N.J.R. 1928(a)	R.1993 d.360	25 N.J.R. 3154(a)
7:25-5	1993-94 Game Code	25 N.J.R. 1930(a)	R.1993 d.390	25 N.J.R. 3519(a)
7:25-6	1994-95 Fish Code	25 N.J.R. 3053(b)		
7:25-7.13, 14.1, 14.2, 14.4, 14.6, 14.7, 14.8, 14.11, 14.12, 14.13	Crab management	25 N.J.R. 1371(a)		
7:25-11	Introduction of imported or non-native shellfish or finfish into State's marine waters	24 N.J.R. 3660(a)		
7:25-18.1, 18.14	Summer flounder permit conditions	25 N.J.R. 2167(a)		
7:25A-1.2, 1.4, 1.9, 4.3	Oyster management	25 N.J.R. 754(a)		
7:26-1.4, 9.3	Hazardous waste management: satellite accumulation areas	25 N.J.R. 1864(a)		
7:26-2.11, 2.13, 2B.9, 2B.10, 6.2, 6.8	Solid waste flow through transfer stations and materials recovery facilities	24 N.J.R. 3286(c)		
7:26-6.6	Procedure for modification of waste flows	25 N.J.R. 991(a)		
7:26-7.7, 8.20	Used motor oil recycling	24 N.J.R. 2383(a)	R.1993 d.342	25 N.J.R. 2863(a)
7:26-8.8, 8.12, 8.19	Handling of substances displaying the Toxicity Characteristic	25 N.J.R. 753(a)		
7:26-8.13, 8.16, 8.19	Hazardous waste listings: F024 and F025	25 N.J.R. 755(a)	R.1993 d.351	25 N.J.R. 3155(a)
7:26-12.3	Hazardous waste management: interim status facilities	24 N.J.R. 4253(a)		
7:26A-6	Used motor oil recycling	24 N.J.R. 2383(a)	R.1993 d.342	25 N.J.R. 2863(a)
7:26B-1.3, 1.5, 1.6, 1.8, 1.9	Environmental Cleanup Responsibility Act (ECRA) rules: operative date of amendments	_____	_____	25 N.J.R. 3155(b)
7:26B-1.3, 1.10, 1.11, 1.12	Environmental Cleanup Responsibility Act Program fees	25 N.J.R. 1375(a)		
7:27-1.4, 2.1, 8.1, 8.2, 16, 17.1, 17.3, 17.4, 23.1-23.7, 25.1, 25.7	Air pollution by volatile organic compounds: control and prohibition	25 N.J.R. 3339(a)		
7:27-8.1, 8.3, 8.27	Air pollution control: requirements and exemptions under facility-wide permits	24 N.J.R. 4323(a)	R.1993 d.428	25 N.J.R. 4075(b)
7:27-15.1, 15.2, 15.4-15.10	Air quality management: enhanced inspection and maintenance program	25 N.J.R. 3322(a)		
7:27-19	Control and prohibition of air pollution from oxides of nitrogen	25 N.J.R. 631(a)		
7:27-26	Low Emissions Vehicle Program	25 N.J.R. 1381(a)		
7:27A-3.2, 3.10	Air pollution civil administrative penalties	25 N.J.R. 3339(a)		
7:27A-3.5, 3.10	Control and prohibition of air pollution from oxides of nitrogen: civil administrative penalties	25 N.J.R. 631(a)		
7:27B-3.1, 3.10	Air pollution sampling and analytical procedures	25 N.J.R. 3339(a)		
7:27B-4.1, 4.5–4.10	Air quality management: enhanced inspection and maintenance program	25 N.J.R. 3322(a)		
7:28-15, 16.2, 16.8	Medical diagnostic x-ray installations; dental radiographic installations	25 N.J.R. 7(a)		
7:28-15, 16.2, 16.8	Medical diagnostic x-ray installations; dental radiographic installations; extension of comment period	25 N.J.R. 1039(a)		
7:29-1.1, 1.2, 2	Determination of noise from stationary sources: extension of comment period	25 N.J.R. 1425(a)		
7:31	Toxic Catastrophe Prevention Act Program	25 N.J.R. 1425(b)	R.1993 d.358	25 N.J.R. 3156(a)
7:32	Energy conservation in State buildings	25 N.J.R. 1655(a)	R.1993 d.347	25 N.J.R. 2868(a)
7:36	Green Acres Program: opportunity to review draft rule revisions	25 N.J.R. 1473(a)		
7:36	Green Acres Grant Program	25 N.J.R. 3405(a)		
7:61	Commissioners of Pilotage: licensure of Sandy Hook pilots	24 N.J.R. 3477(a)	R.1993 d.385	25 N.J.R. 3534(a)

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HEALTH—TITLE 8				
8:2	Creation of birth record	24 N.J.R. 4325(a)	R.1993 d.397	25 N.J.R. 3771(a)
8:2	Creation of birth record: reopening of comment period	25 N.J.R. 660(a)		
8:2A-1	Access to death records	25 N.J.R. 3115(a)		
8:18	Catastrophic Illness in Children Relief Fund Program	25 N.J.R. 2169(a)	R.1993 d.438	25 N.J.R. 4128(a)
8:21-3.13	Repeal (see 8:21-3A)	24 N.J.R. 3100(a)		
8:21-3A	Registration of manufacturers and wholesale distributors of non-prescription drugs, and manufacturers and wholesale distributors of devices	24 N.J.R. 3100(a)		

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8:23-6	Pilot low-cost spaying and neutering clinic surgery fees	25 N.J.R. 3116(a)		
8:24	Packing of refrigerated foods in reduced oxygen packages by retail establishments: preproposal	25 N.J.R. 660(b)		
8:24-8, 9	Temporary and mobile retail food establishments and agricultural markets	25 N.J.R. 1965(b)	R.1993 d.345	25 N.J.R. 2872(a)
8:31B	Hospital financing: correction to proposal	25 N.J.R. 3566(a)		
8:31B-1.1	Hospital financing	25 N.J.R. 3117(a)		
8:31B-2, 3.70	Hospital reimbursement: bill-patient data submissions; revenue cap monitoring	25 N.J.R. 1660(a)	R.1993 d.362	25 N.J.R. 3205(a)
8:31B-3.41, 4.38, 4.39, 4.40, 7	Hospital reimbursement: uncompensated care	25 N.J.R. 3125(a)		
8:31B-4.41-4.41N	Hospital reimbursement: charity care audit functions	25 N.J.R. 3707(a)		
8:33	Certificate of Need: application and review process	25 N.J.R. 2171(a)	R.1993 d.442	25 N.J.R. 4129(a)
8:33-3.11	Certificate of Need process for demonstration and research projects	24 N.J.R. 3104(a)		
8:33A-1.2, 1.16	Hospital Policy Manual: applicant preference; equity requirement	24 N.J.R. 4476(a)		
8:33A-1.10, 1.16, 1.29	Hospital Policy Manual: capital cap and review process	25 N.J.R. 3710(a)		
8:33E	Cardiac diagnostic facilities and surgery centers: certificate of need	25 N.J.R. 3712(a)		
8:33H	Long-term care services: certificate of need policy	25 N.J.R. 3719(a)		
8:33S	Surgical facilities: certificate of need	25 N.J.R. 2790(a)		
8:34	Nursing home administrators: standards for licensing	25 N.J.R. 3727(a)		
8:36	Assisted living residences and comprehensive personal care homes: standards for licensure	25 N.J.R. 3734(a)		
8:39	Long-term care facilities: licensing standards	25 N.J.R. 1474(a)	R.1993 d.341	25 N.J.R. 2878(a)
8:40-1.1, 2.3, 2.7, 3.1, 4.12, 5.23, 6.26	Invalid coach and ambulance services: licensure; street EMS	25 N.J.R. 2663(a)		
8:41-4.1, 10.5-10.13, 11	Mobile intensive care programs: standing orders; paramedic clinical training objectives	25 N.J.R. 2665(a)		
8:42B	Drug treatment facilities: standards for licensure	25 N.J.R. 1476(a)	R.1993 d.340	25 N.J.R. 2879(a)
8:43	Licensure of residential health care facilities	25 N.J.R. 25(a)		
8:43	Licensure of residential health care facilities: public hearing	25 N.J.R. 757(a)		
8:43A	Ambulatory care facilities: public meeting and request for comments regarding Manual of Standards for Licensure	24 N.J.R. 3603(a)		
8:43A	Licensure of ambulatory care facilities	25 N.J.R. 757(b)	R.1993 d.443	25 N.J.R. 4140(a)
8:44-2.1, 2.14	Clinical laboratory licensure: HIV testing	25 N.J.R. 2184(a)		
8:44-2.11	Clinical laboratories: reporting by supervisors	25 N.J.R. 3751(a)		
8:57-3.2	Physician reporting of occupational and environmental diseases and injuries	25 N.J.R. 2186(a)		
8:59-1, 2, 5, 6, 9, 11, 12	Worker and Community Right to Know Act rules	25 N.J.R. 864(a)	R.1993 d.384	25 N.J.R. 3543(a)
8:59-3.1, 3.2, 3.3, 3.5-3.9, 3.11, 3.13-3.17	Worker and Community Right to Know Act: trade secrets and definitions	25 N.J.R. 858(a)	R.1993 d.386	25 N.J.R. 3537(a)
8:59-5.6	Worker and Community Right to Know: exclusions from labeling requirements	25 N.J.R. 3441(a)		
8:59-App. A, B	Worker and Community Right to Know Act: preproposal concerning Hazardous Substance List and Special Health Hazard Substance List	25 N.J.R. 792(a)		
8:70	List of Interchangeable Drug Products: evaluation and acceptance criteria	25 N.J.R. 1814(a)	R.1993 d.333	25 N.J.R. 2879(b)
8:71	Interchangeable drug products (see 24 N.J.R. 2557(b), 3173(a), 4260(b); 25 N.J.R. 582(a))	24 N.J.R. 1674(a)	R.1993 d.226	25 N.J.R. 1970(b)
8:71	Interchangeable drug products (see 24 N.J.R. 3174(c), 3728(a), 4262(a); 25 N.J.R. 583(a))	24 N.J.R. 2414(b)	R.1993 d.338	25 N.J.R. 2882(b)
8:71	Interchangeable drug products (see 24 N.J.R. 4261(a); 25 N.J.R. 582(b))	24 N.J.R. 2997(a)	R.1993 d.225	25 N.J.R. 1970(a)
8:71	Interchangeable drug products (see 25 N.J.R. 580(b))	24 N.J.R. 4009(a)	R.1993 d.339	25 N.J.R. 2883(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1221(a), 1969(c))	25 N.J.R. 55(a)	R.1993 d.337	25 N.J.R. 2882(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1970(c))	25 N.J.R. 875(a)	R.1993 d.336	25 N.J.R. 2881(b)
8:71	Interchangeable drug products	25 N.J.R. 1814(b)	R.1993 d.335	25 N.J.R. 2881(a)
8:71	Interchangeable drug products	25 N.J.R. 1815(a)	R.1993 d.334	25 N.J.R. 2879(c)
8:71	Interchangeable drug products list	25 N.J.R. 2802(a)		
8:71	Interchangeable drug products	25 N.J.R. 2802(b)		
8:100	State Health Planning Board: public hearings on draft chapters of State Health Plan	24 N.J.R. 3788(a)		
8:100	State Health Plan: draft chapters	24 N.J.R. 3789(a)		

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8:100	State Health Plan: draft chapters on AIDS, and preventive and primary care	24 N.J.R. 4151(a)		
8:100	State Health Plan: invalidation of rules	_____	_____	25 N.J.R. 3772(a)
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HIGHER EDUCATION—TITLE 9				
9:1	Licensing and degree approval standards	25 N.J.R. 3057(a)		
9:1-5.11	Regional accreditation of degree-granting proprietary institutions	24 N.J.R. 3207(a)		
9:2-11	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1323(a)		
9:5-2.1, 2.2, 2.3, 2.5, 2.7	Job training program: unemployed persons tuition waiver	25 N.J.R. 3593(a)		
9:7-2.6	Student assistance programs: independent student status	25 N.J.R. 1945(a)	R.1993 d.388	25 N.J.R. 3464(a)
9:7-9	Paul Douglas Teacher Scholarship Program	25 N.J.R. 3594(a)		
9:9	NJHEAA student loan programs	25 N.J.R. 2187(a)	R.1993 d.441	25 N.J.R. 4079(a)
9:11-1.1, 1.2, 1.4, 1.6, 1.10, 1.22, 1.23	Educational Opportunity Fund: student eligibility for undergraduate grants	25 N.J.R. 1663(a)		
9:11-1.5	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	25 N.J.R. 1946(a)		
	Most recent update to Title 9: TRANSMITTAL 1993-4 (supplement May 17, 1993)			
HUMAN SERVICES—TITLE 10				
10:3	Contract administration	25 N.J.R. 3694(b)		
10:4	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1323(b)		
10:8	Patient advance directives; DNR orders; declaration of death	25 N.J.R. 2669(a)		
10:15-1.2	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)	R.1993 d.396	25 N.J.R. 3772(b)
10:15A-1.2	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)	R.1993 d.396	25 N.J.R. 3772(b)
10:15B-1.2, 2.1	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)	R.1993 d.396	25 N.J.R. 3772(b)
10:15C-1.1	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)	R.1993 d.396	25 N.J.R. 3772(b)
10:31-1.4, 2.1, 2.2, 2.3, 8.1, 9.1	Screening and Screening Outreach Programs: mental health services	25 N.J.R. 1324(a)		
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10:37A	Community residences for mentally ill adults	25 N.J.R. 2672(a)		
10:37B	Psychiatric community residences for youth	25 N.J.R. 2197(a)		
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10:38A	Pre-Placement Program for patients at State psychiatric facilities	24 N.J.R. 4326(a)	R.1993 d.356	25 N.J.R. 3213(a)
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10:51	Pharmaceutical Services Manual	24 N.J.R. 3053(a)	R.1993 d.434	25 N.J.R. 4082(a)
10:51-5.6	Pharmaceutical services: income eligibility limits	25 N.J.R. 3407(a)		
10:52-1.9, 1.13	Reimbursement methodology for distinct units in acute care hospitals and for private psychiatric hospitals	24 N.J.R. 4477(a)		
10:52-1.23	Inpatient hospital services: adjustments to Medicaid payer factors	24 N.J.R. 4478(a)		
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10:69-5.8; 69A-5.4, 5.6, 6.12, 7.2; 69B-4.13	HAAAD, PAAD, and Lifeline programs: fair hearing requests, prescription reimbursement, benefits recovery	24 N.J.R. 4329(a)	R.1993 d.368	25 N.J.R. 3216(a)

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10:69A-1.2, 6.2	PAAD income eligibility limits	25 N.J.R. 3407(a)		
10:69B	Lifeline Programs	25 N.J.R. 3701(a)		
10:69B-4.2	Lifeline programs: income eligibility limits	25 N.J.R. 3407(a)		
10:71-4.8, 5.4, 5.5, 5.6, 5.9	Medicaid Only: eligibility computation amounts	25 N.J.R. 1818(a)	R.1993 d.402	25 N.J.R. 3786(a)
10:72-1.1, 4.1, 4.5	New Jersey Care—Special Medicaid Manual: specified low-income Medicare beneficiaries	25 N.J.R. 1042(b)	R.1993 d.369	25 N.J.R. 3217(a)
10:81-2.2, 2.3, 5.1, 7.40-7.47, 15	Fraudulent receipt of AFDC assistance; disqualification penalties	25 N.J.R. 3408(a)		
10:81-8.22	Medicaid eligibility of dependent child of adolescent parent	25 N.J.R. 2815(a)		
10:81-11.4, 11.16A, 11.20	Public Assistance Manual: closing criteria for IV-D cases; application fee for non-AFDC applicants	25 N.J.R. 881(a)		
10:81-11.7, 11.9	Non-AFDC child support orders	25 N.J.R. 2816(a)		
10:81-11.21	Review and adjustment of child support orders in AFDC, foster care, and Medicaid Only cases	25 N.J.R. 2818(a)		
10:81-14.18A	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:82-3.14	Deeming income of parents or guardians of adolescent parent	25 N.J.R. 2819(a)		
10:82-5.3	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
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10:84-1	Administration of public assistance programs	24 N.J.R. 4480(b)		
10:85-1.1, 3.1, 3.2, 4.2, 7.2	Eligibility for employable GA recipients	25 N.J.R. 1714(a)	R.1993 d.382	25 N.J.R. 3466(a)
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10:121A-5.,10	Requirements for adoption agencies: searches	25 N.J.R. 3415(a)		
10:123-3.4	Personal needs allowance for eligible residents of residential health care facilities and boarding houses	25 N.J.R. 2684(a)		
10:126	Family day care registration: manual of requirements	25 N.J.R. 3703(a)		
10:127	Residential child care facilities: manual of requirements	25 N.J.R. 1716(a)	R.1993 d.403	25 N.J.R. 3787(a)
10:133C-4	Division of Youth and Family Services: case goals	25 N.J.R. 1947(a)		
10:133D-2	DYFS case management: case plan	25 N.J.R. 2209(a)		
10:133D-4	DYFS case management: in-person visits with clients and substitute care providers	25 N.J.R. 2210(a)		
10:140	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1326(a)		

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10A:1-1.2, 2.7	Rulemaking petitions; rule exemptions: administrative changes	_____	_____	25 N.J.R. 4105(a)
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10A:2-6.2, 6.3, 6.4	Investigation of adult and juvenile inmate property claims: administrative changes	_____	_____	25 N.J.R. 3218(a)
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11:1-31	Surplus lines insurer eligibility	25 N.J.R. 1819(a)		
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11:1-32.4, 35	Insurance holding company systems	Emergency (expires 10-15-93)	R.1993 d.445	25 N.J.R. 4275(a)
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11:1-36	Examination of insurers	Emergency (expires 10-15-93)	R.1993 d.446	25 N.J.R. 4284(a)

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11:2-28	Credit for reinsurance	Emergency (expires 10-15-93)	R.1993 d.448	25 N.J.R. 4289(a)
11:2-33.4	Workers' compensation self-insurance: administrative correction	_____	_____	25 N.J.R. 4179(a)
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11:17-7	Reinsurance intermediaries	Emergency (expires 10-15-93)	R.1993 d.455	25 N.J.R. 4323(a)
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12:23-5	Workforce Development Partnership Program: application and review process for additional unemployment benefits during training	25 N.J.R. 887(a)		
12:23-6	Workforce Development Partnership Program: application and review process for employment and training grants for services to disadvantaged workers	25 N.J.R. 1054(a)		
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12:100-4.2	Public employee safety and health: occupational exposure to bloodborne pathogens	24 N.J.R. 3607(b)	R.1993 d.323	25 N.J.R. 2894(a)
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12A:9	Development of small businesses and women and minority businesses	25 N.J.R. 1752(a)	R.1993 d.309	25 N.J.R. 2689(a)
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13:30-1.1	Board of Dentistry: qualifications of applicants for licensure to practice	25 N.J.R. 2216(d)		
13:30-8.5	Board of Dentistry: complaint review procedures	24 N.J.R. 2800(a)	Expired	
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Most recent update to Title 14: TRANSMITTAL 1993-3 (supplement June 21, 1993)

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Most recent update to Title 15: TRANSMITTAL 1993-2 (supplement May 17, 1993)

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16:28-1.41	Speed limit zones along U.S. 9 in Berkeley Township and Pine Beach Borough	25 N.J.R. 1834(a)	R.1993 d.327	25 N.J.R. 2913(c)
16:28-1.48, 1.93	Speed rates along Route 167 in Port Republic and Route 44 in Greenwich and West Deptford	25 N.J.R. 2225(a)	R.1993 d.400	25 N.J.R. 3841(a)
16:28-1.92	Speed limit zones along Route 169 in Bayonne and Jersey City	25 N.J.R. 2834(a)		
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16:28A-1.20, 1.25, 1.31, 1.41	Restricted parking and stopping along Route 29 in Lambertville, Route 35 in Berkeley Township, Route 45 in Woodbury, and Route 77 in Bridgeton	25 N.J.R. 3127(a)		
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